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Values in Psychotherapy: A Philosophical Analysis of the Normative Assumptions in Freud's Psychoanalysis, Sullivan's Interpersonal Theory of Psychiatry and Frankl's Logotherapy

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VALUES IN PSYCHOTHERAPY: A PHILOSOPHICAL ANALYSIS OF THE NORMATIVE ASSUMPTIONS IN FREUD'S PSYCHOANALYSIS, SULLIVAN'S INTERPERSONAL THEORY OF PSYCHIATRY AND FRANKL'S LOGOTHERAPY

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For Michael Harling, the one beautiful mystery in my life

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ABSTRACT

Since the 1960's, there has been a growing consensus among health professionals and philosophers that psychotherapy involves a question of values. During that time, most contemporary work has been directed at two questions: 1) What are the values that therapist's make use of when treating a client? and 2) What is the justification for the presence of and reliance on these values? Current debate in this arena has been fueled by differing responses to these questions. As a result, little agreement exists regarding the number, nature, ordering and grounding of these values.

The aim of this dissertation is to encourage some consensus in this arena by clarifying a proper locus for a discussion of values in therapy. In contrast to authors that establish a basis for values in various philosophical or religious ideologies, I argue that scholars need to look to the school of thought to which a therapist adheres. I believe that if scholars analyze the philosophical assumptions implicit in paradigms of psychotherapy, including notions of mental illness, view of reality, etc., they may begin to see the normative force that these assumptions create both within the therapeutic context and as the goal of therapy. It could be agreed, then, that while values in therapy are *relative* to a school of thought, *universal* prescriptions and prohibitions are made use of by the therapist and transmitted to the patient. In this way, psychotherapists and clinical ethicists could generate a consistent, rational plan of

action for the benefit of the client.

Three historically significant paradigms of psychotherapy are analyzed in this dissertation, namely Freud's psychoanalysis, Sullivan's interpersonal theory of psychiatry and Frankl's logotherapy. Their implicit philosophical assumptions are explored along with considerations of their normative force for the client who seeks this kind of treatment. A final concluding chapter considers the contemporary state of psychotherapy and a modern school of thought, short-term dynamic therapy.

INTRODUCTION

> And are we to believe that a man who takes in hand a shield or any other instrument of war springs up on that very day a competent combatant in heavy armor or in any other form of warfare -- though no other tool will make a man be an artist or an athlete by his taking it in hand, nor will it be of any service to those who have neither acquired the science of it nor sufficiently practiced themselves in its use?[1]

> Where pity is preached today -- and if you listen closely, this is the only religion preached now -- psychologists should keep their ears open: through all the vanity, through all the noise that characterizes these preachers (like all preachers) they will hear a hoarse, groaning, genuine sound of *self-contempt*..... The man of "modern ideas," this proud ape is immeasurably dissatisfied with himself; that is certain. He suffers -- and his vanity wants him to suffer only with others, to feel pity.---[2]

Since the 1960's, there has been a growing consensus among health professionals and philosophers that psychotherapy involves a question of values. During that time, most contemporary work has been directed at two questions: 1) What are the values that therapist's make use of when treating a client? and 2) What is the justification for the presence of and reliance on these values? Current debate in

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[1] Plato. *The Republic,* in *The Collected Dialogues including the Letters,* ed. by Edith Hamilton and Huntington Cairns, (New Haven: Princeton University Press, 1961), II, 374d, 621.

[2] Friedrich Nietzsche. *Beyond Good and Evil,* trans. and with commentary by Walter Kaufmann (New York: Random House, 1966), 149-150.

this arena has been fueled by differing responses to these questions. As a result, we presently find ourselves with little agreement regarding the number, nature, ordering and grounding of these values.

The aim of this dissertation, as originally conceived, was to attempt to achieve some consensus in this arena by clarifying a proper locus for a discussion of values in therapy. In contrast to authors that establish a basis for values in various philosophical or religious ideologies, I wished to argue that those who wish to write on this topic needed to look *within* the paradigm/school of thought to which a therapist adheres. I believed, then, that if one were to sufficiently analyze the philosophical assumptions implicit in schools of thought, an analysis if you will of their notions of mental illness, view of reality, etc., one could begin to see the normative force that these assumptions created both within the therapeutic context and as the goal of therapy. If the normative force of these philosophical assumptions could be established, then it could be agreed that while values in therapy are *relative* to a school of thought, *universal* prescriptions and prohibitions are made use of by the therapist and transmitted to the patient. In this way, psychotherapists and clinical ethicists could generate a consistent, rational plan of action for the benefit of the client. In sum, I believed that if values could be discussed as *intra-paradigm* phenomena, at the very least, consensus could be achieved regarding values based upon the commitment of the therapist - if one were to identify themselves as a Freudian, Sullivanian, Frankelian Logotherapist, etc. To my knowledge and to date, no study exists on the nature of norms within paradigms of psychotherapy. Not only

for its benefit to clients, but also for its novelty, I pursued this idea.

So conceived, the thesis itself depended upon two assumptions only. Since these assumptions still operate in this work, I will address them now. The first assumption is that there are such things as "schools of thought" or *paradigms* as I choose to call them, firmly established and adhered to by psychotherapists. The use of the term, *paradigms,* is inspired by Thomas Kuhn. In the *Function of Dogma in Scientific Research,* Kuhn articulates both the definition and the main features of scientific paradigms. He says:

> A paradigm is a possession of which enabled scientists to take the foundation of their field for granted and to push on to more concrete and recondite problems. Features: 1) A paradigm is a fundamental scientific achievement and one which includes both a theory and some exemplary applications to the results of experiment and observation. 2) A paradigm is an accepted achievement in the sense that it is received by a group whose members no longer try to rival it or create alternatives for it. 3) A paradigm is an open-ended achievement, one which leaves all sorts of research to be done.[3]

In terms of definition as well as the main features, most importantly that paradigms articulate a "theory and some exemplary applications" of it, I believe that there are identifiable *paradigms* in psychotherapy. While presently, there is much debate as to the number and kinds of legitimate forms of psychotherapy are operative in the disciplines, the *fact* that there are schools of thought in psychotherapy, conceived of broadly, as Kuhn articulated them is sufficient to generate my thesis. For the purposes

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[3] Thomas Kuhn. "The Function of Dogma in Scientific Research," in *Readings in the Philosophy of Science*, ed. by Baruch Brody. (New Jersey: Prentice-Hall, 1970), 368-71.

of this dissertation, I have chosen to confine my analysis to four such paradigms, of which all share the features of Kuhn's paradigms. They are: Freud's Psychoanalysis, Harry Stack Sullivan's Interpersonal Theory of Psychiatry and Viktor Frankl's Logotherapy. In addition to meeting the requirements of Kuhn's paradigm, all are sufficiently comprehensive to demonstrate competing metaphysical and normative commitments. But also, the most currently accepted and widely practiced form of therapy, Short-Term Dynamic Therapy has its historical and philosophical foundations in these schools of thought.

The second assumption of the project has to do with my attempt to derive *normative* assumptions from *philosophical* assumptions. By declaring to do so, I have automatically chosen a side in the continuing debate on the fact/value distinction. Historically, it is David Hume who forged the distinction between descriptive claims and prescriptive claims, which commonly falls under the rubric of the Naturalistic Fallacy. He says:

> In every system of morality, which I have hitherto met with, I have always remark'd that the author proceeds for some time in the ordinary way of reasoning, and establishes the being of a God, or makes observations concerning human affairs; when of a sudden I am surpriz'd to find, that instead of the usual copulations of propositions, *is,* and *is not,* I meet with no proposition that is not connected with an *ought,* or *ought not.* For as this *ought,* or *ought not,* expresses some new relation or affirmation, `tis necessary that it shou'd be observ'd and explain'd; and at the same time that a reason should be given, for what seems altogether inconceivable, how this new relation can be a deduction from others, which

are entirely different from it.[4]

While Hume rightly was attacking the metaphysicians, or the zealots, when he wrote this, today, I would argue that in the absence of metaphysical truths, Hume's naturalistic fallacy is a rather mute point. There is a large and growing tradition, those who honestly and despairingly are forced to acknowledge the death of metaphysics as a discipline and concomitantly inspired by Kantian epistemology, upon which I can soundly rest assured that a hard and fast distinction between facts and values must be sufficiently blurred.

Provided that the reader could accept the two assumptions, the project itself seemed doable and necessary. As the work proceeded, I kept myself abreast of the current scholarly contributions to the discussion of values. Again, while most contributors are aware of the fact that there *are* values in therapy; there seemed to be a growing movement *away* from any base-line consensus regarding values in psychotherapy. Much to my dismay, the growing disparity in treatment of values, I believe, covertly contributes to a growing belief that values are arbitrary or relative. For the sake of acquainting the reader with how values have been and are discussed, I offer the following schematization or review of the literature.

1) Multi-Cultural Values: These authors suggest that in their practice, therapists should take into consideration cultural or gender values of their clients. See for example: Harry J. Aponte. *Bread and Spirit: Therapy with the New Poor: Diversity of Race, Culture and Values* (New York: Norton, 1994).; Rosemarie Perez Foster, Michael Moskowitz and Rafael Art Javier, eds. *Reaching Across Boundaries of*

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[4] David Hume. *Treatise of Human Nature,* 2nd ed. Edited and with an analytical index by L.A. Selby-Bigge. With text revised and variant readings by P.H. Nidditch. (Oxford: Clarendon Press, 1978), III, i, i, 470.

Culture and Class: Widening the Scope of Psychotherapy (New Jersey: Jason Aronson, Inc., 1996).; J. Pamela Weiner and Pauline Boss. "Exploring Gender Bias Against Women: Ethics for Marriage and Family Therapy. Special Issue: Values and Ethics in Family Therapy," *Counselling and Values* 38(1) (October, 1985): 9-23.

2) Religious/Philosophical Values: These scholars argue that the proper foundation for a discussion of values in therapy rests with religious or philosophical values. Examples include: Everett L. Worthington, ed. *Psychotherapy and Religious Values.* (Michigan: Baker Book House, 1993).; Martin Lakin. *Ethical Issues in the Psychotherapies.* (Oxford: Oxford University Press, 1988).; Allen E. Bergin. "Psychotherapy and Religious Values," in *Journal of Consulting and Clinical Psychology 48* (1980): 95-105.; P. London. *The Modes and Morals of Psychotherapy.* (New York: Holt, Rinehart and Winston, 1964).

3) Personal Values: For several decades, researches have conducted studies which verify that a therapist's personal values do impact clinical practice. Aware of this, some scholars have suggested that therapists explore their own personal value system prior to practice. The literature includes: Morris B. Parloff, Norman Goldstein and Boris Iflund. "Communication of Values and Therapeutic Change," *Archives of General Psychiatry*, 2 (1960): 300-4.; Hans H. Strupp. "Humanism and Psychotherapy: A Personal Statement of the Therapist's Essential Values," *Psychotherapy: Theory, Research and Practice* 17(4) (Winter, 1980): 396-400. Paul Chodoff. "Ethical Dimensions of Psychotherapy: A Personal Perspective," *American Journal of Psychotherapy*, vol. 50, no. 3 (Summer, 1996), 298-310.; Janet A. Khan and Darryl G. Cross. "Mental Health Professionals: How Different are there Values?" *American Mental Health Counselors Association Journal,* 6 (January, 1984): 32-51.; E. Weisskopf-Joelson. "Values: The Enfant Terrible of Psychotherapy," *Psychotherapy: Theory, Research and Practice,* 17 (1980): 459-66.; Jerry Dragan. "An Examination of the Role of Values in Counselling and Psychotherapy," *Canadian Counsellor* 8(4) (October, 1974): 272-9.; John C. Norcross and Michael Wogan. "Values in Psychotherapy: A Survey of Practitioner's Beliefs," *Professional Psychotherapy: Research and Practice* (18)1 (February, 1987): 5-7.

4) Political Values: Several scholars have argued that all therapists implicitly transmit accepted political values to their clients. As such, therapy is construed as "applied politics." For example, see: Peter Breggin. "Psychiatry and Psychotherapy as Political Processes," *American Journal of Psychotherapy,* vol. 29 (1975): 369-87.; S. Halleck. *The Politics of Therapy.* (New York: Science House, 1971).; Jonas Robitscher. *The Powers of Psychiatry.* (Boston: Houghton-Mifflin, 1980).

5) Therapy as Value-Neutral: Some commentators are adamant that therapy is a value-neutral process. If clients adopt values at the end of therapy, it is argued that they have *freely* chosen to do so. In principle, though, therapists are not in the business of advancing values to their clients. Rather, they only encourage the client to

become a fully autonomous agent. See: Thomas Szasz. *The Myth of Mental Illness* (New York: Harper & Row, 1974).; and *The Ethics of Psychoanalysis* (New York: Basic Books, 1965). H. Tristram Englehardt. "Psychotherapy as Meta-ethics," in *Psychotherapy and Ethics,* ed. by Rem B. Edwards, (New York: Prometheus Books, 1982).

There is much overlap in these categories; however, I list them so as to familiarize the reader with how values have been discussed in the past and presently. And presently, with this growing proliferation of views, the possibility of consensus *so as to provide a coherent, rational plan of action* for the client seems sadly out of reach.

Having identified the four paradigms to be analyzed, I began the work on this project, in the only way possible, at the beginning -- with the *theoretical articulation* of these schools of thought. Guided by the view that theory is linked to practice, I focused my research on their respective *descriptions* (philosophical assumptions) of mental illness, reality (both internal and external, as conceived of by the therapist and the client, and at various times in the course of therapy), the therapeutic techniques of the school of thought and the purported goals of treatment. I read the secondary literature which sought to clarify or to further develop these descriptions. In the end, I was forced to conclude that while in the *abstract* my original thesis was still on target, the *theory* of these schools of thought was often poorly articulated, at times inconsistent and at its worst moments, positively confused. The implications of this discovery were manifold.

First and foremost, it stands to reason that if the theory upon which practice is supposed to be based is skewed, then practicing *within a school of thought* must be equally ambiguous. This caused me to wonder *what* exactly practitioners of

psychotherapy purport to be "doing" in the confines of therapy and *how* they are justifying the methodology behind their practice. In a very real sense, those who claim that a therapist's personal values enter into therapy, are in the end, somehow correctly speaking to what actually occurs in practice. However, I am not convinced that their reasons for believing this claim rest on the appropriate arguments. In my view, if, therapists rely on personal values, it is often because the *theory* to which they adhere allows for a random selection of normative claims. In a very real sense, because of the deeply entrenched meta-analytical confusion, therapists who base their practice on these paradigms are unwittingly led to a reliance on *their* personal values. This was especially the case with Frankl's Logotherapy and Short-Term Dynamic Therapy.

But secondly, since the task of uncovering the philosophical assumptions proved to be enormous; and given that there was seldom *a meaning,* but rather multiple plausible *meanings* of these philosophical assumptions, my belief in the possibility of establishing a clear, consistent and coherent ethic for each of the paradigms was turning into a distant dream. The original thesis underwent a severe modification. I decided that turning the spotlight on the theory of these paradigms itself -- a clarification of the philosophical assumptions-- was where work needed to be done. The project has since been construed as a meta-analysis of the philosophical assumptions inherent in these schools of thought with the intent of understanding what implications they *might* have for a normative ethic and/or where scholars need to focus their attention in order to clarify the normative ethic. This has especially been true of

Chapters 1: Freud's Psychoanalysis and Chapter 2: Harry Stack Sullivan's Interpersonal Theory of Psychiatry.

My greatest desire would be that psychotherapists would use this dissertation as a tool by which to begin investigating the *interpretation* that they give to the descriptive assumptions within their schools of thought in order to understand the normative force that this has for their client. A more modest desire would be that therapists use this dissertation as a tool by which to begin reflecting about the assumptions within and behind their practice. Yet, greater or smaller, I am doubtful that *many* therapists will do this. As I worked on this dissertation, I came across many warrants in the exposition of theory that precluded therapists from rationally examining any theory whatsoever. In sum, there are rather obvious prohibitions directed at therapists to not think too deeply; for, to travel too far into critical thought might risk one being labelled as "obsessional." The following passages are worth citing *and* critiquing:

> For obsessional neurosis "seduces" the obsessional neurotic to a particular philosophical position, namely that world-view of hundred-per-centness of which we have spoken above. A case that shows the obsessional-neurotic world-view in its incipient stages is that of a young man in late puberty. Amid the labor pains of adolescence it became plain that an obsessional-neurotic world-view was setting in.
>
> The young man in question was filled with a Faustian urge to know the roots of everything. "I want to get back to the origin of things," were his words. "I want to be able to prove everything; I want to prove everything that is immediately obvious -- for example, whether I am living."
>
> We know that the obsessional neurotic's sense of obviousness

is defective.[5]

I find it fascinating that Viktor Frankl, trained in philosophy himself, has not the patience to make clear distinctions between the following concepts, namely: a) one's *desire* for absolute proof, b) the *possibility* of achieving absolute proof and c) the pejorative and unjust labelling of someone as showing the symptoms of obsessional-neurosis. A desire *to know* has long been deemed the hallmark of what separates human beings from the animal kingdom. Indeed, it is this desire which founded and propelled the entire discipline of philosophy, also known as the most divine science, according to Aristotle. With respect to b), whether or not it is possible to know all things has long been debated by the greatest scholars in the halls of academia. Yet, b) is a philosophical question and should be debated as such, not *treated* by therapy. By claiming that a pre-adolescent *suffers* the symptoms of obsessional neurosis because he *wonders* about the world around him is nothing short of an affront to the entire human race. I would humbly urge that Frankl should rather escort this youth to the halls of the university and out of the logotherapist's office. From Aristotle's point of view, after *treatment* in this therapist's office, something less than a human being would emerge -- and ultimately, thanks to the *professional work* of the logotherapist.

> There is hardly a criticism that has not been leveled at psychotherapy: it is ineffective; it is dangerous; it is too limited, too long, too expensive; carried on in the secrecy of the consulting room, its techniques remain arcana unavailable to scientific scrutiny..., etc.
> The *dedicated* (emphasis added) psychotherapist is

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[5] Viktor E. Frankl. *The Doctor and the Soul: From Psychotherapy to Logotherapy.* rev. and expanded ed. (New York: Vintage Books, 1986), 195-6.

> undaunted by these frequently contradictory comments. He *knows from his own experience that his treatment methods work* (emphasis added), and he is aware that the demand for rigorous proof comes from those who like their world to be an orderly place and expect natural phenomena to conform to the clear definitions and sharply delineated categories of ideal reason. God is less *obsessional* (emphasis added), and the real world of creation is full of stubborn facts that refuse to be marshalled or quantified; nowhere is this more true than in the realm of human subjective experience and the psychology that studies it.[6]

Aware of the criticisms, this psychiatrist urges other dedicated psychiatrists to rest assured that their expertise is based upon *the individual practitioner's* experience that *his* treatment method works. This kind of reasoning is viciously circular. It is akin to my saying that this chapter is "good" simply because I say it is good. As such, this view makes a mockery of psychotherapy because it suggests that the *theory* upon which therapists base their practice is something *wholly subjective.* In addition, and much like my criticism of Frankl's remarks, it insults an individual's rationality, but in particular it denigrates the rationality of all therapists. It precludes any attempt to understand objectively the nature of their own *expertise* or *profession.* Individuals who attempt to understand it, instead, are accused of trying to be God-like and/or are guilty of obsessionality. After reading this passage, the rational reader may query: *who really is afflicted with the madness of God-like hubris?*

But paradoxically, one of the most discomfiting passages I encountered was written by an esteemed psychologist and one who is himself a critic of psychotherapy. I call this paradoxical because given the nature of his criticism, Robyn Dawes is

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[6] Dr. Nemiah. Introduction to *Short-Term Anxiety Provoking Therapy: A Treatment Manual* by Peter E. Sifneos. (New York: Basic Books, 1992), vii-viii.

clearly an individual who is quite willing to be labelled as "obsessional" and challenge the credibility of many established principles of psychotherapy. In his recent book, *House of Cards: Psychology and Psychotherapy Built on Myth*, he has the following advice for *clients* who seek therapy. He advises them as follows:

> There is no reason, however, to seek out a highly paid, experienced therapist with a lot of credentials. If verbal therapy is sought, paraprofessionals are equally effective, especially empathetic ones. If the problems appear to require behavioral modification, as do phobias and lack of impulse control, a paraprofessional who understands behavioral principles is as effective as a highly credentialed professional. But, success in therapy is far from assured, even though it works overall in a statistical sense. Someone who is dissatisfied with their current progress in therapy should not be inhibited about changing therapists or mode of treatment. (The therapist that is abandoned may attribute this decision to the depth of the clients pathology, but so what).[7]

But so what? So what is the client is not a professional therapist and does not know if he suffers from an illness that requires "behavioral modification" such as "phobias and lack of impulse control." And, so what if a client believes that persons who call themselves *professional therapists, require a fee, and purport to help them* can not assure them of "success" in therapy? And, so what if a client is told that their pathology is so severe and that this is the reason why therapy has not worked even though the *real reason* may lie elsewhere? And so what if a client is so mentally disabled that he may not even be able to believe in the truth -- let alone even to cognize - *his own so what?*

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[7] Robyn Dawes. *House of Cards: Psychology and Psychotherapy Built on Myth* (New York: Free Press, 1994), 73.

> *What* about the *person* who is the client?
>
> *What* about psychotherapists whose sole *professional* and *moral* justification for engaging in the work they do is to *help clients?*

I conclude this introduction with two comments. First, I would like to invite psychotherapists to peruse this dissertation. Those who are willing to invoke critical reason and who risk being labelled as "obsessional," at the very least may personally benefit from examining the foundational assumptions of four historically and comprehensive theoretical paradigms of psychotherapy. These paradigms, though not exhaustive, have served as the disciplinary bedrock of the professional status of psychotherapists. Though the chapters do not promise a complete account of the normative commitments implicit in these theories, as I dreamed they might, I believe they point toward important implications for further investigating the integral role that descriptions and prescriptions play within the paradigm of which they are a part. In this respect, I would gladly welcome a further articulation of the thoughts presented here -- for the sake of theory, practice and the welfare of clients treated in this profession.

Finally, I began this introduction with two quotes: one from Plato which emphasizes the importance between the relationship between theory and practice, but the second was from Nietzsche. With his prophetic aphorisms, Nietzsche scorned the history of western philosophy and Christianity because of their preaching a morality to human beings which actually further enslaved man to a mythology and destroyed that which is most ennobling to him. Nietzsche warns that "psychology" might become the

new, modern religion -- and psychotherapists, its new missionaries. But, this is only a warning. If psychotherapists are to accomplish what society and their professions *believe* that they will do, psychotherapists must heed his warning and look critically at their practice. He says:

> In short, my dear psychologists, study the philosophy of the "norm" in its fight against the "exception:" there you have a spectacle that is good enough for gods and godlike malice! Or, still more clearly: vivisect the "good man," the *homo bonae voluntatis" -- yourselves!*[8]

I have only one additional clause to add to this warning: ... do so for *your clients!*

[8] Nietzsche, *Beyond,* 147.

CHAPTER ONE

THE NORMATIVE ASSUMPTIONS OF THE ANALYST IN FREUD'S PSYCHOANALYSIS

> But there is one question which I can hardly evade. If the development of civilization has such a far-reaching similarity to the development of the individual and if it employs the same methods, may we not be justified in reaching the diagnosis that, under the influence of cultural urges, some civilizations, or some epochs of civilization -- possibly the whole of mankind -- have become 'neurotic?' An analytic dissection of such neuroses might lead to therapeutic recommendations which could lay claim to great practical interest. I would not say that an attempt of this kind to carry psycho-analysis over to the cultural community was absurd or doomed to be fruitless. But we should have to be very cautious and not forget that, after all, we are dealing only with analogies and that it is dangerous, not only with men but also with concepts, to tear them from the sphere in which they have originated and been evolved. Moreover, the diagnosis of communal neuroses is faced with a special difficulty. *In an individual neurosis we take as our starting-point the contrast that distinguishes the patient from his environment, which is assumed to be 'normal'* (emphasis added). For a group all of whose members are affected by one and the same disorder no such background could exist; it would have to be found elsewhere. *And as regards the therapeutic application of our knowledge, what would be the use of the most correct analysis of social neuroses, since no one possesses authority to impose such a therapy upon the group* (emphasis added)? But in spite of all these difficulties, we may expect that one day someone will venture to embark upon a pathology of cultural communities.[1]

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[1] Sigmund Freud. *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, trans. by James Strachey, 24 vols. (London: Hogarth Press, 1953-1974), 21: 144.

The above quote is taken from the last pages of Freud's, *Civilization and Its Discontents*. As he states, a final problem which he can "hardly evade" has to do with the possibility of the existence and modes of understanding along psychoanalytic lines of a culture/civilization -- indeed a whole race of mankind -- that suffers from neurosis. It is interesting to note that as soon as he raises the thought experiment and points out the potential difficulties in addressing it, Freud dismisses it and leaves it to his future scholars to undertake an investigation of the pathology of cultural communities. Only one and one-half pages later, Freud concludes *Civilization and Its Discontents.*

Let me state at the outset, that in this chapter my aim is not to take up the task of sketching out the pathology of cultural communities. Rather, I quoted Freud's thought experiment at length because it seems to me that in later years, when his inquiries became more philosophical in nature, Freud was the first to acknowledge that psychoanalysts take as their *starting point* a vision of the environment which they assume to be "normal." Indeed, it is this knowledge of the "environment" (or civilization) which justifies the authority of psychoanalysts and makes its practice possible.

Contemporary discussions of the legitimacy of psychotherapy as a discipline could benefit from a reconsideration of Freud's claim. In a recent critical review of the literature on psychotherapy, Stephen Logan remarks:

> Modern psychotherapy is vexed with the problem of its own authority. A number of influential therapists -- among them Peter Lomas, Adam Phillips and Anthony Storr -- have recently written books which agonize over

> the question of the kind and degree of authority a therapist should claim. In a liberal society with an eroded moral consensus, moral guides are likely to be needed and resented equally. The former sources -- religion, social tradition, literature -- are either not available, or else the practice of consulting them has come to feel naive. Therapists, who have often laboriously rebuilt some degree of the moral confidence their patients lack, are therefore apt to be regarded as gurus.[2]

I believe that Freud would have been disconcerted with Logan's characterization of the state of psychotherapy today. Repeatedly in his writings, Freud emphasizes the need to keep psychoanalysis firmly entrenched in the medical community in order to avoid analysts being viewed as charlatans. It seems to me that in light of the passage in *Civilization and Its Discontents*, Freud was well aware of the fact that psychoanalysis involved *some* normative considerations and he offered the suggestion that civilization itself provides the proper grounding for these values. After all, the psychoanalyst uses as his starting point a vision of the "environment which he assumes to be normal." In this way, were he alive today, Freud might respond to Logan's remarks by saying that the "authority" with which psychoanalysis -- indeed *any* form of therapy -- is derived is from civilization itself.

In this chapter, I intend to engage in a limited excursion into the Freudian corpus in order to elucidate his conception of the nature of this "normal environment." This description, as offered in his later works, comes replete with an exposition of the

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[2] Stephen Logan, "The Charisma of Uncertainty: Challenges to Psychotherapy in the Postmodern Age," *Times Literary Supplement,* (September 27, 1996), 27-28. See also: Peter Kramer, *Moments of Engagement: Intimate Psychotherapy in a Technological Age* (New York: Penguin Books, 1989), 187-219.

kinds of characters and social institutions that are found in society. By assessing the nature of these institutions, it is hoped that readers may begin to glimpse its normative force. I believe that it is this understanding of "reality" that serves as the starting point for the practice of psychoanalysis. However, since there are ambiguities surrounding the term "reality" as used by Freud, an initial portion of this chapter will be devoted to categorizing the many meanings of this word. Having done so, I will then limit my analysis solely to Freud's conception of phenomenal reality and demonstrate how it is imbued with pain and misery. It is this kind of "reality" which functions as the horizon against which Freudian psychoanalysts treat their clients.

In order to establish this thesis, this chapter will assume the following structure:

1) Review of the literature: the role of the psychoanalyst
2) Transition
3) Stipulation of texts
4) The many meanings of reality
5) The nature of phenomenally shared reality
6) Summary and transition to private property
7) Private property
8) Considerations of religion
9) Conclusion

1) Review of the literature: the role of the psychoanalyst

The Freudian corpus contains a host of passages which allow for competing interpretations regarding the role of the psychoanalyst. In my view, there are at least three qualitatively different ways in which Freud characterizes this role and each implies different normative notions. After identifying these passages in Freud's works, I then wish to align them with three contemporary understandings of the role of the psychoanalyst. All of these interpretations are partially correct, in my view, yet, they

fail to take into account the ultimate "starting point" for the practice of psychoanalysis, namely civilization itself. In this section, each contemporary view will be presented and followed by a brief critique. This will pave the way for the normative considerations assumed in Freud's description of civilization.

Let us begin by considering three groups of citations which allow for competing views. Each of the passages falls under the following three headings, namely: 1) The psychoanalyst as impartial, 2) The psychoanalyst as engaged in a hermeneutic endeavor; and 3) The psychoanalyst as suggesting personal values. The reader should be aware that in these passages, Freud is not addressing the psychoanalyst's *methods* per se; but rather, the analyst's *demeanor* that is presupposed prior to his application of the methods, specifically of free association and dream interpretation. In addition, it is important to note that in this chapter, I am not concerned with the therapeutic "relationship" that is formed in psychoanalysis, but only the normative vision of reality that is assumed on the part of the psychoanalyst. Having made these stipulations, consider the following passages:

View 1: The psychoanalyst as impartial

> But psycho-analysis has already weathered many storms and now it must brave this fresh one. In point of fact psycho-analysis is a method of research, an impartial instrument, like the infinitesimal calculus, as it were.[3]

> Psychoanalysis, in my opinion, is incapable of creating a *Weltanschauung* of its own. It does not need one; it is a part of science and can adhere to the scientific *Weltan-*

[3] Freud, *SE* 21: 43.

schauung.[4]

> I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible. .... The justification for requiring this emotional coldness in the analyst is that it creates the most advantageous conditions for both parties; for the doctor a desirable protection for his own emotional life and for the patient the largest amount of help that we can give him today.[5]

View 2: The psychoanalyst engaged in a hermeneutic endeavor

> But it is far from being the case that his ego is content to play the part of passively and obediently bringing us the material we require and of believing and accepting our translation of it. A number of other things happen, a few of which we might have foreseen but others of which are bound to surprise us. The most remarkable thing is this. The patient is not satisfied with regarding the analyst in the light of reality as a helper and advisor who, moreover, is remunerated for the trouble he takes and who would himself be content with some such role as that of a guide on a difficult mountain climb.[6]

> Accordingly, the first part of the help we have to offer is intellectual work on our side and encouragement to the patient to collaborate in it.[7]

> As a rule we put off telling him of a construction or explanation till he himself has so nearly arrived at it that only a single step remains to be taken, though that step is

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[4] Ibid., 22: 181.

[5] Ibid., 10: 115.

[6] Ibid., 23: 174.

[7] Ibid., 23: 177.

in fact the decisive synthesis.[8]

View 3: The psychoanalyst as suggesting personal values:

> We serve the patient in various functions, as an authority and a substitute for his parents, as a teacher and educator; and we have done the best for him, if as analysts, we raise the mental processes in his ego to a normal level, transform what has become unconscious and repressed into preconscious material and thus return it once more to the possession of his ego.[9]
>
> On that particular matter our knowledge will then have become his knowledge as well.[10]
>
> However much the analyst may be tempted to become a teacher, model and ideal for other people and to create men in his own image, he should not forget that is not his task in the analytic relationship, and indeed that he will be disloyal to his task if he allows himself to be led on by his inclinations.[11]

The flavor of each of these passages suggests different understandings of the role of the psychoanalyst and consequently, implies different values assumed in practice. Scholars have used these passages for explaining the role the psychoanalyst should adopt in practice. The following is a brief list of the scholars who have generated theories that align with the above passages: 1) has been advocated by H. Tristram Englehardt and Thomas Szasz; 2) by Paul Ricouer, Arnold Goldberg and Hans G. Gadamer; and 3) by Allen E. Bergin, Kerry Brace and Martin Lakin.

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[8] Ibid., 23: 178.

[9] Ibid., 23: 181.

[10] Ibid., 23: 178.

[11] Ibid., 23: 175.

Following an explanation and critique of these views, I will suggest an alternative interpretation regarding how one can more plausibly interpret the guiding assumptions of the psychoanalyst based on Freud's views of reality. It is hoped that this final view will enlarge and recast prevalent ideas that the psychoanalyst is neutral, interactive, or uses personal values within the confines of psychoanalysis.

View 1: The psychoanalyst as impartial/neutral

Relatively few philosophers have maintained that the practice of psychoanalysis is an entirely value-neutral enterprise; nonetheless, the few that have done so have argued quite rigorously and persuasively for this approach. Notably, those who have defended this view are H. Tristam Englehardt in *Psychotherapy as a Meta-Ethics*[12] and Thomas Szasz in *The Ethics of Psychotherapy.*[13] In brief, Englehardt conceives of the practice of psychoanalysis as a meta-ethic, aiming only at the value of autonomy. If clients adopt values at the end of therapy, it is not because the analyst *imposes* or *suggests* them to the client; but rather, clients freely choose to accept them. In principle, though, Englehardt believes that analysts are not in the business of advancing or suggesting values to clients. Thomas Szasz largely adopts this view, modifying the language slightly by referring to psychoanalysis as a meta-education.

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[12] H. Tristram Englehardt. "Psychotherapy as Meta-Ethics," in *Psychotherapy and Ethics,* Rem B. Edwards, ed. (New York: Prometheus Books, 1982).

[13] Thomas Szasz, *The Ethics of Psychoanalysis* (New York: Basic Books, 1965). See also: Rangell, L. "Similarities and Differences between Psychoanalysis and Dynamic Psychotherapy," *Journal of the American Psychoanalytic Association,* vol. 2 (1954): 734-44.

To a greater degree than Englehardt, Szasz more fully develops the notion that therapy itself is a purely contractual endeavor, made and agreed upon by two autonomous individuals.

In many of his writings (and as evidenced in the citations), Freud seemingly wants to align the entire discipline of psychoanalysis, as well as its methods, with the apparent neutrality of that of the natural sciences. Accordingly, the analyst would be viewed by analogy as a surgeon and the methods of free association and dream interpretation would be construed as neutrally employed. In other words, the role of the psychoanalyst would consist of the objective application of techniques. In this way, psychoanalysts could be conceived as neutral practitioners of an objective discipline or science.

Several criticisms lend themselves to the Szasz/Englehardt interpretation. First, Although Freud *speaks* this way, it is questionable as to whether or not he truly advocates this view. Clearly, the passages in section 2 and 3 -- where Freud talks about the analyst's role as an educator, advisor, confessor, etc. -- seem to indicate that he was anything but certain about the possibility of an objective practice of psychoanalysis. Conflicting textual evidence alone warrants suspicion regarding the neutrality of the psychoanalyst.

Second and more importantly, what these authors fail to address is that even if one were to align psychoanalysis with the natural sciences, it is difficult to conceive of an objective or "impartial" application of a technique in any discipline whatsoever. Even if most commentators agreed that Freud's psychoanalysis was absolutely like the

objective sciences, in light of the work of Thomas Kuhn,[14] objective science itself is replete with values. In other words, natural science is just *one* paradigm, or one way of choosing to portray the world amongst many. By default, those who choose to practice within one paradigm as opposed to another are themselves making a value-laden decision.[15]

By way of combining the first and second points, one might note that the methods of psychoanalysis[16] may, in and of themselves be considered "neutral," that is, by definition or in an abstract, conceptual form. However, the methods when practiced -- involving an individual's application of theory -- opens up the door to normativity in psychoanalysis. Contemporary philosophy of language supports this view. Recognition of the personal and unconscious aspects of language reveals that the methods of psychoanalysis have an inescapable value-laden dimension.[17]

Thirdly, and more specific to a refutation of the views of Szasz and Englehardt, both believe that psychoanalysts only encourage one value in the course of therapy, namely "autonomy." As a result, if the client adopts any other value at the end of

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[14] Kuhn, *Function of Dogma*, 368-371.

[15] Support for this view also comes from within the psychoanalytic community For an example, see: Howard B. Levine. "The Analyst's Participation in the Analytic Process," *International Journal of Psychoanalysis,* vol. 75, (1994): 665-676. See in particular p. 667: whether or not a value-free psychoanalysis is possible or even desirable is widely debated in the psychoanalytic community.

[16] The reader should note that when I refer to the methods of psychoanalysis, I primarily refer to the methods of free association and dream interpretation.

[17] Ferdinand Saussure. *Course in General Linguistics* (New York: Philosophical Library, 1959). See also: Jacques Lacan. *Ecrits: A Selection,* trans. by Alan Sheridan. (New York: W.W. Norton & Company, 1977).

therapy, they claim that the client alone bears responsibility for this decision. However, passages in the Freudian corpus directly undermine this view. Freud was aware that at the *outset* and *during* treatment, client's are not fully autonomous agents and consequently, are not fully responsible for their choices. At the very least, Freud himself would appear to acknowledge that clients are "susceptible" to an analyst's suggestion of values. For instance, one might consider the following passage in *An Outline of Psychoanalysis:*

> The method by which we strengthen the *weakened ego* (emphasis added) has as a starting point an extending of its self-knowledge. That is not, of course, the whole story but it is a first step. The loss of such knowledge signifies for the ego a *surrender of power and influence;*(emphasis added) it is the first tangible sign that it is being hemmed in and hampered by the demands of the id and the super-ego. Accordingly, the first part of the help we have to offer is intellectual work on our side and encouragement to the patient to collaborate in it. [18]

If autonomy is compromised to begin with, as Freud says it is, this is sufficient to raise a serious question as to whether or not the analysand is capable of discriminating effectively between the those interpretations that are truly *his* and those that are suggested by *his analyst,* both during and at the end of treatment. This point could even lead one to the paradoxical conclusion that the supposed "objective practice of psychoanalysis may be highly suggestive of values to the client in the course of treatment.[19]

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[18] Freud, *SE* 23: 177.

[19] Ernest Wallwork. *Psychoanalysis and Ethics* (New Haven: Yale University Press, 1991), 210.

Finally, construing the role of the psychoanalyst as neutral ignores Freud's understanding of the inherent asymmetrical relationship between analyst and analysand. A cursory consideration of Freud's text, *On Beginning the Treatment,* is sufficient to say that he was well aware of this imbalance of power. In that text, Freud was careful to privilege psychoanalysts with a special fund of knowledge, certain professional norms etc. In short, he expounded upon the *moral* obligations that are required in the professional practice of psychoanalysis.[20] The norms listed in this text transcend an understanding of the therapeutic relationship as one agreed to by two, autonomous agents. In direct opposition to Englehardt's and Szasz's view, Freud seems to suggest that the psychoanalyst is, in a very real sense, a moral agent of some sort.

In conclusion, and as I have tried to argue, both external to and internal to the Freudian corpus, the views expressed by Englehardt and Szasz may be rendered seriously questionable in light of the above considerations. If this is the case, then while the *methods* of psychoanalysis may be neutral, the practice of psychoanalysis is not.

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[20] For an example, see Freud, *SE* 12: 134. There, Freud says that psychoanalysts may wish to sit out of the sight of the patient during analysis. Not only for practical purposes is this recommended (i.e. the fact that it is tiring to look at persons for eight hours a day and that it enables the client to free-associate and thus engage in the method of psychoanalysis); but also, this recommendation, I would argue has a moral dimension to it as well. He says: "I insist on this procedure, however, for its purpose and result are to prevent the transference from mingling with the patient's own imperceptibly, to isolate the transference and to allow it to come forward in due course sharply defined as resistance." Arguably, the moral dimension of this "practical" prescription is to enable the analyst to avoid imposing his own suggestions/interpretations on to the analysand. See also: *SE* 12: 139-141 for a similar example in which Freud encourages therapists to avoid early interpretation.

View 2: The psychoanalyst as engaged in a hermeneutic task

Midway between these extremes one finds the literature by the hermeneuticians. Psychoanalytic truth, as argued by Ricouer and Gadamer, lies in the interpretative process or the movement of the dialogue within the analytic encounter between the analyst and analysand.[21] Such an account admits of a general description of the therapeutic endeavor as an encounter which is inherently subjective, or better stated inter-subjective, and dependent upon the two individuals involved in the dialectical exchange.[22]

There is one major assumption underlying the hermeneutic view of psychoanalysis, namely, the aim to obliterate the subject/object distinction within the therapeutic relationship. Because of this it follows that the therapeutic relationship is portrayed by an overarching "intersubjectivity" between the analyst and the analysand. As one can see, for either party to claim neutrality in terms of knowledge or values is a mute point. Goldberg succinctly explains the role of the psychoanalyst on this view:

> In contrast to Rubovitz-Seitz and Hirsch is the claim of Hans Georg Gadamer (1965), who states that a fusion of horizons between interpreter and interpreted, or between one person trying to understand another, necessarily and inevitably changes both. Thus, interpretation is not the

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[21] H.G. Gadamer, "The Historicity of Understanding," in *The Hermeneutics Reader,* K. Mueller-Vollmer, ed., (New York; Continuum, 1989). See also: Paul Ricoeur, *Freud and Philosophy* (New Haven: Yale University Press, 1970). For similar views advanced in the psychoanalytic community, see: O.H.D. Blomfield, "The Essentials of Psychoanalysis," *Australian and New Zealand Journal of Psychiatry,* vol. 27, (1993): 86-100.

[22] See A. Goldberg's, "Farewell to the Objective Analyst," *International Journal of Psychoanalysis,* vol. 75, (February, 1994): 21-30.

> study of a static or fixed object, but a process of participation: the creation of a shared meaning.[23]

Given the aforementioned passages from the Freudian corpus, there does seem to be evidence that he saw the truth of analysis as a mutual product -- involving as it does dual participation and interaction between the analyst and analysand in the sharing and creation of meanings. However, and in spite of this, two objections based on the Freudian corpus itself, seem seriously to undermine the strength of the hermeneutic view. They are: 1) the hermeneutic view seems to rest upon a confusion between the method and the role of the psychoanalyst in the therapeutic situation; and most importantly 2) I believe that if a psychoanalyst were to adopt the hermeneutic approach to treatment, he could not actually be consistent with the nature of the methods of psychoanalysis.

With respect to the first issue, when Freud speaks about what the analyst *learns* in the clinical encounter, typically it is to indicate what he learns about the *theory* of psychoanalysis *in general.*[24] Hence, when Freud speaks in general about the importance of practicing psychoanalysis -- the importance of looking to and learning from the clinical case -- it is really not due to the fact that the actual interaction between analyst and analysand will *together* yield new data which are of significant interest to the analyst; but rather, the data coming from the analysand will reveal to the

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[23] Ibid., 24.

[24] For an excellent example, see the opening pages of Freud's *On Narcissism, SE* 14: 73-75. There, one will find Freud addressing how individual clinical encounters aided in the development of his theory on narcissism.

analyst new truths or ideas about the *theory* upon which the technique of psychoanalysis rests.[25]

Even in its most suggestive form, when Freud does speak as if the truth of psychoanalysis is intersubjectively constituted, one must always remember that for him the relationship between analyst and analysand is asymmetrical. Hence the truth that is established in this sort of relationship is biased, for it is the analyst's knowledge that is privileged above and beyond all. I believe that this underlying vantage point or one-sided perspective affects the actual degree to which a true bi-partisan notion of shared meaning can result. For example, in numerous texts Freud cautions the analyst not to impart knowledge (that *he* possesses) too quickly to the analysand who has yet to discover this knowledge on his own.[26] Such passages are key to discerning the different and more extensive knowledge that the analyst possesses in contrast to the analysand. Inter-subjective truths may ultimately constitute *some* of the knowledge that is achieved at the *end* or as the *goal* of analysis. However, knowledge as a mutual product is not the *sole* kind of knowledge to be considered in analysis. This

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[25] One might consider any one of Freud's process notes of his clinical encounters in order see the force of this point. For example, consider his notes on the Rat Man, *SE* 10: 318. Typically, Freud will cite the specific facts of the case; but these tend to be immediately followed by another statement which indicates how this specific material corroborates or challenges established theory. Here is but one of many examples: "There was suppressed anger against his friend Springer, whose authority thus originates from this, and against another man who betrayed him and whom, in return, he had later helped at the cost of sacrifices. Thus we find ever-increasing suppression of the instinct of anger, accompanied by a return of the erotogenic instinct for dirt."

[26] Ibid., *SE* 12: 134, 139-141.

being the case, what hermeneuticians fail to recognize is that it is possible through suggestive questions/interpretations that the prior knowledge of the analyst actually configures what is to be learned in analysis *to a greater extent* than what the analysand contributes.

In a slightly different vein, what I think the hermeneuticians have a tendency to overlook, and frankly what Freud did not, is that characterizing the knowledge gained in analysis as a mutual product actually undermines the expertise of the psychoanalyst. Granted that to some degree, the analyst and analysand inevitably work together in the creation of meanings; however, the shared meaning which accrues in the end, will be radically different for each of the parties, both in degree and content. To fully realize this point, hermeneuticians need only consider what kind of knowledge would result if one considered treatment of a psychotic and a neurotic.[27] Presumably, the more severe the mental illness of the client, the less the client can *meaningfully* contribute to and even be said to understand the "shared truth" derived from analysis. The two participants *in* the analytic situation are of an unequal status.

View 3: The psychoanalyst as suggesting personal values

In contrast to this extremist position, other scholars have maintained that the perspective of reality and the concomitant values assumed are of a highly personal

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[27] See *SE* 14: 74. There, Freud reminds us that psychoanalysis is incapable of treating the paraphrenic because he has so "loosened his connections with external reality -- people and things." Because of this, Freud says: "In consequence of the latter change, they become inaccessible to the influence of psychoanalysis and cannot be cured by our efforts."

nature. Such a position has been advocated by Lakin,[28] Brace,[29] Bergin.[30] This view mitigates the possibility of an intradisciplinary agreement as to the view of reality employed by therapists and the values they rely upon. Overall, it implies that all patients are affected by the worldviews and normative notions of the *individual* therapist. Not surprisingly, such a thesis lends itself to these authors' superimposition of ethical justifications and/or a hierarchical ordering of the values that therapists *should* make use of within therapy. Typically, antiquated philosophical and religious ideologies have been appealed to for such an ordering of values.

In many passages, Freud warns psychoanalysts to avoid making use of or advancing personal values in the analytic session. A technique recommended by which to overcome this tendency to rely on personal values was for the psychoanalyst to undergo his own analysis. If this could not entirely eliminate the transmission or suggestion of personal values, at the very least it could a) make the analyst self-aware of the values that he holds and by doing so, b) diminish the possibility or degree of

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[28] Martin Lakin. *Ethical Issues in the Psychotherapies* (Oxford: Oxford University Press, 1988).

[29] Kerry Brace, "Nonrelativist Ethical Standards for Goal Setting in Psychotherapy," *Ethics and Behavior,* vol 2, no. 1, (1992): 15-38.

[30] Allen E. Bergin, "Proposed Values for Guiding and Evaluating Counseling and Psychotherapy," *Counseling and Values,* vol. 29, no.2, April, 1985: 99-116. See also: Allen E. Bergin, "Psychotherapy and Religious Values," in *Journal of Consulting and Clinical Psychology,* vol. 48, (1980): 95-105; J.P. Jensen and A. E Bergin, "Mental Health Values of Professional Therapists: A National Interdisciplinary Survey," *Professional Psychology: Research and Practice*, vol. 19, (1988): 290-7; James Drane, "Ethics and Psychotherapy," in *Ethics and Values in Psychotherapy: A Guidebook* in Rem B. Edwards (New York: Free Press, 1982).

their transmission to the patient.

Contemporary scholars typically have a mixed reaction to Freud's desire for objectivity on this point. Many claim that psychotherapists invariably rely on personal values, for better or for worse. Others, attempting to move beyond this view, encourage psychoanalysts to be consciously aware as to the selection of the kinds of values they advance to their patients. Attempts have been made to hierarchically order these values in terms of their importance and universality and to argue for their relevance in the clinical encounter. As mentioned earlier, these values often have as their justification arguments extrinsic to psychoanalysis itself (i.e. in major ethical or religious theory, etc.)

In agreement with these individuals, and again aligning myself with Kuhn, it seems probable that some of the analyst's personal values are transmitted to the patient within therapy -- whether consciously or unconsciously. In some sense, then, efforts made by these commentators to acknowledge these values and provide a justification for them does seem laudable. However, my contention with such efforts is simply that personal values are not -- indeed, *can not be* -- the only values with which analysts must be concerned. As I will argue later in this chapter, not only are personal values a concern; but what should take precedence is those values which are implicit in the paradigm of psychoanalysis itself.

Ironically, these author's attempts to identify values are in my view, both too limited and too broad. For example, Bergin claims that the value of "respect for persons" advanced in therapy is justified in light of Kant's moral philosophy. In order

to determine if indeed the principle of "respect for persons" is advocated in any form of therapy *and* in order to determine what its justification is, I would claim that one should rather look to the paradigm in which this principle may be said to play a role. In other words, Freud (while developing his account of psychoanalysis) might have advocated a respect for persons within the therapeutic situation, but the justification more properly may be said to follow from claims internal to the theory of psychoanalysis itself. In this respect, then, when commentators appeal to traditions external to the school of thought, they have a tendency unduly to broaden the range of justifying the presence of these values. On the other hand, by choosing to overlook justifications for values internal to the theory of which they are a part, these commentators run the risk of failing to identify other values operative in the practice of psychoanalysis.

2) Transition

Having seen what is problematic or incomplete about contemporary accounts of normative notions assumed by the psychoanalyst, in this section I wish to turn to a consideration of Freud's later, sociological works in order to see what the appropriate "starting point" for a consideration of values might be in psychoanalysis. First, we will turn our attention to unpacking the varied meanings of "reality" in the Freudian corpus. Categorizing his use of the term is foundational to understanding what kind of knowledge of reality is assumed as the starting point for the practice of psychoanalysis. Having established this, we will then consider Freud's broader

understanding of society as explained in his works, *Civilization and Its Discontents* and *The Future of an Illusion.* By doing this, I will attempt to glean out important "descriptive" aspects of how individuals function in society and why this is the case according to Freud. The descriptive project then will be shown to carry normative force in the sense that the external world embodies values that are reflective of an individual's instinctual nature. In attempting to fulfill our pleasure-seeking nature, society thwarts these natural desires and drives.[31] If we assume that the therapist possesses knowledge of this kind of reality and this concomitant theory of human nature, then we can presume that this vision provides the backdrop against which the analysand is treated. Given this thesis and the enormity of the Freudian corpus, let me begin with a brief justification for the texts that I will use.

3: Stipulation of texts

Although often cited as speculative works on the origin of society, I have chosen to look at *Civilization and Its Discontents* and *The Future of an Illusion* for several reasons: 1) they were written toward the end of Freud's life when his interests turned to more philosophical speculations and he was able to reflect, in a broader sense, on the contribution of his psychoanalytic theory to other disciplines, and 2) I think they illustrate quite nicely his hopes for the future.

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[31] Much has been made about Freud's understanding of the term "instincts." In this chapter, I refer to instincts as basic human drives. For an excellent analysis of the role of instincts and morality, see Donald C. Abel. *Freud on Instinct and Morality* (New York: State University of New York Press, 1989).

4: The many meanings of "reality

Assessing Freud's distinctions of external and internal reality from a philosophical perspective is in some sense unjust. Freud never aimed to do philosophy per se; but rather, his psychoanalysis grew out of his observations of clinical cases. Nonetheless, throughout his theoretical works and possibly within his psychoanalytic practice, Freud relied upon decidedly philosophical concepts, notably his notions of external and internal reality. In order to determine how Freud understood these concepts, I suggest it is useful to look at them from the point of view of the history of philosophy that he inherited. Again, though not a philosopher himself, Freud was well aware of the western philosophical tradition.[32]

Ever since philosophy took the reflexive turn with Descartes, philosophers have been concerned with the existence of objective reality. While Descartes moved from a position of radical skepticism to having "proven" the existence of being, his knowledge of the existence of external reality was based on specious proofs for the existence of God. For it was only in his having shown that God exists and lacks a deceiving nature which enabled him to trust the clarity and distinctness of his perceptions -- one of which was that objective reality exists and has a certain definable nature. The Cartesian wave of optimism did not last long. Soon thereafter, David Hume seemed to have shown definitively that the nature of our mind is such that it can never know the

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[32] For an excellent summary of how Freud was influenced by the western philosophical tradition, see: Lewis A. Kirshner, "Concepts of Reality and Psychic Reality in Psychoanalysis as Illustrated by the Disagreement Between Freud and Ferenczi," *International Journal of Psycho-Analysis,* vol. 74, (1993): 219-230.

natural world, let alone demonstrate the existence, of external reality. It was left to Immanuel Kant to resolve the apparently contradictory positions of these two philosophers. This he accomplished by drawing the distinction between phenomenal and noumenal reality.

Kant's own stance as to the nature of noumena was rather obscure: noumena are inherently unknowable, yet, persons must presume the existence of things-in-themselves because phenomenal reality has to be caused by something from without. However, phenomenal reality, was ultimately the only thing that persons could be said to know.

I took the liberty of this brief excursion into modern philosophy to point out the tradition that Freud inherited and with which he was apparently familiar. Although Freud sometimes slips into talking like a realist (in the sense that there is an objective reality that is knowable in itself), there are enough passages to suggest that Freud really aligned himself with the Kantian tradition. Consider for example the following passage in *The Future of an Illusion.* When extolling the virtues of science, Freud claims...

> Finally an attempt has been made to discredit scientific endeavor in a radical way, on the ground that, being bound to the conditions of our own organization, it can yield nothing else than subjective results, whilst the real nature of things outside ourselves remains inaccessible. But this is to disregard several factors... (namely), that the task of science is fully covered if we limit it to showing how the world must appear to us in consequence of the particular character of our organization.... and, the problem of the nature of the world without regard to our percipient mental apparatus is an empty abstraction,

devoid of practical interest.[33]

I suspect it is safe to say that given Freud's optimism for natural science, he may have been inconsistent with his language and sometimes fell into the trap of talking like a realist; yet, overall, as the above passage indicates, I think Freud truly believed in the Kantian resolution to the problem of human knowledge of reality. Noumena are inherently unknowable; all that persons can be said to know is a subjective experience of reality.

Interestingly, there is yet another basis of comparison between Freud and Kant. Kant certainly wanted to avoid the conclusion that our mental life is radically subjective. Rather, given the structure of the human mind and the faculties for knowing, the data of phenomenal experience are necessarily structured accordingly. Kant's categories allow, then, for a high degree of similarity between human ways of knowing. Persons structure experience in regular ways, namely, by means of cause and effect, temporality, etc.

I believe that Freud roughly had the same idea as Kant's in mind. In other words, though he did not advocate the same transcendental structures of the mind that Kant did, by positing a theory of human nature of basic and fundamental instinctual drives, stages of development, etc. Freud believed that phenomenal experience was not something *radically* subjective. By and large, for him, there is a horizon of experience that tends to get structured by individuals in certain concrete, predictable ways.

In some sense, although there is good evidence as I have tried to show between

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[33] Freud, *SE* 21: 55-6.

Kant's bifurcated sense of reality and Freud's adoption of this and their view that the mind somehow structures phenomenal reality, these points are rather peripheral to the thesis that I wish to develop in this chapter. The main point to note, though, and what will be helpful for this chapter is that in most cases where Freud refers to external reality it is best to interpret him as referring to phenomenally shared reality. As external reality tends to be used in his later works, namely in *Civilization and Its Discontents* and *The Future of an Illusion,* external reality refers to this intersubjective vision of the world or of society --- replete with its institutions, political forms, other persons, etc. It is this vision of a phenomenally shared reality that is charged with normativity in my view. This should not be surprising, given Freud's adherence to the Kantian tradition in which the knower is said to *contribute* to the object known. For Freud, and as I will argue in this chapter, because of our human nature, persons infuse their perception of reality with the twin values of pain and misery.[34]

At this point, someone might object and claim that in the above account I have confused Freud's notions of internal (psychic) reality and external reality (phenomenally shared understanding of reality). Some might claim that individual psychic reality (private reality) already implicitly contains a sense of "external reality." Such a criticism is not entirely unjust. Although there is debate about what Freud

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[34] As a note to the reader, I chose to use the terms "pain and misery," because Freud himself often uses these words in *Civilization and its Discontents.* At times, he replaces them with the term "suffering." For the purposes of this chapter, I simply intend to show that our perception of the world is colored for Freud, with "negativity." This alone is what "pain is misery" is intended to refer to.

actually understood by psychic reality,[35] in general most scholars agree that there are two broad ways of construing this term. They are: 1) psychic reality as an individual's private subjective experiences; and 2) psychic reality as consisting of the unique aspects of our internal mental structures of the unconscious-preconscious-conscious system.[36]

So as to avoid the above criticism and with an attempt to be clear and consistent with Freud's usages of the term, "reality," I believe that there are at least four different meanings he assigns to this term. They are: 1) objective reality (things in themselves); 2) phenomenally shared vision of reality or external reality as inter-subjectively understood; 3) an individual's own inner psychic reality (private reality) inclusive of unconscious data that will become known in the course of the analysis; and 4) the general structures of the mind.[37] With these categorizations in place, let us now turn to the thesis of this chapter.

5: The nature of phenomenally shared reality

In some sense, if this section were simply intended to be a brief overview of the

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[35] See for example: Modell, A., "A Confusion of Tongues or Whose Reality is It?" *Psychoanalytic Quarterly,* vol. 60, (1991): 227-44.

[36] For an excellent overview of Freud's notions of reality, see Robert Michels. "Introduction to Panel: Perspectives on the Nature of Psychic Reality," Fall Meeting of the American Psychoanalytic Association, *Journal of the American Psychoanalytic Association,* vol. 33, no. 3, (1983): 515-19.

[37] Specific passages in the Freudian corpus which seem to support this categorization are: *SE* 21: 66-68 (for definitions 1, 2 and 4); *SE* 23: 76-8 (for definitions 1, 3 and 4); *SE* 23: 201 (for definitions 1, 2, and 4).

general patterns in which individuals relate to each other and/or their modes of actions within broader society, we would be retracing familiar ground. Yet, if there is one theme that will be my Archimedean point in this section, it is the recurrent references that Freud makes to our "life" or our vision of the environment (definition 2, above) as permeated with pain and misery. Perceiving reality in this way as charged with normativity, is caused by persons' inner psychic reality (definition 4, above). In other words, a person's phenomenal reality and actual structures of the mind are in a dialectical relationship.[38] Persons perceive external reality as imbued with pain and misery in virtue of, even in spite of, their natural and internal psychic structure. Interestingly, I believe that this thesis has an important implication for what the world is in-itself (definition 1). For Freud, social institutions that exist over and against individuals (i.e. private property) come to be as they are because of this operative dialectic.

In order to develop this view and to show how it relates to the broader thesis of this chapter, two tasks need to be accomplished. First, it is important to "reconstruct,"

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[38] For examples which indicate what this dialectic might look like in other contexts, consider *SE* 6: 257-9: "In point of fact, I believe that a large part of the mythological view of the world, which extends a long way into most modern religions, is nothing but psychology projected into the external world. The obscure recognition (the endopsychic perception, as it were) of psychichal factors and relations is mirrored in the construction of a supernatural reality, which is destined to be changed back one more by science into the psychology of the unconscious." See also *SE* 14: 136: "For the pleasure ego, the external world is divided into a part that is pleasurable which it has incorporated into itself, and a remainder that is extraneous to it. It has separated off a part of its own self, which it projects into the external world and feels as hostile. After this new arrangement, the two polarities coincide once more: the ego-subject coincides with pleasure, and the external world with unpleasure..."

if you will, Freud's vision of this phenomenally shared reality or description of civilization so as to describe wherein this pain and suffering exist in society. This is a central task, because as we know, it is the knowledge of this "environment" itself which serves as the starting point for psychoanalysts. Having accomplished this, we can then move to the second part of this chapter, namely demonstrating how this vision of external reality may be said to enter into the therapeutic encounter because it is already assumed on the part of the therapist. Presumably, having been trained in the theory of psychoanalysis and adopting this vision of external reality as their starting point, psychoanalysts may subtly and legitimately, according to Freud, to be fostering these values in the course of treatment and as an implied goal of therapy.

When turning to Freud's account of the environment in *Civilization and Its Discontents,* one might wonder how it is possible to "see normativity" in a very incomplete account of society. In spite of its incompleteness, one does receive a rather good impression of the *general modes* or *patterns* of civilization's operations, predictions of its future development and types of observable human behaviors. In what follows, we shall examine three different societal institutions that Freud describes rather thoroughly in order to explain his general "sense" of external reality. By exploring these institutions, one will come to see that for Freud, this reality is perceived by humans as replete with pain and misery. These latter values are inescapable elements of human reality. I believe this is caused by the dialectic that I referred to earlier: human nature has created reality to be this way and is, at some

point in time, destined to be frustrated within it.[39] In the end, what will emerge and be important within the confines of psychoanalysis is that life has the "feel" of a perpetual struggle due to the demands of our instinctual nature. A stoic resolve *is encouraged* for persons in order to effectively cope with life in their society.

Early on in *Civilization and Its Discontents,* Freud takes up the question: what is the purpose of human life? Clearly, he claims, religion falsely professes that it knows the purpose of life; yet, Freud retorts "...the question of the purpose of human life has been raised countless times; it has never yet received a satisfactory answer and perhaps does not admit of one."[40] Nevertheless, he proceeds by raising an admittedly more modest but similar question:

> We will therefore turn to the less ambitious question of what men themselves show by their behavior to be the purpose and intention of their lives. What do they demand of life and *wish* (emphasis added) to achieve in it. The answer to this can hardly be in doubt. They *strive* (emphasis added) after happiness.[41]

In the following pages, Freud continues by assessing the unique paths or patterns of behavior that individuals choose in order to find happiness. Among the many different

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[39] It is not necessary that I be specific in this analysis as to *when, where, and how* persons are said to "realize" or even "experience" this pain and misery. Rather, my thesis is restricted solely to the fact that *invariably* persons will "see" reality as imbued with negativity. However, the reader might like to know that in the forthcoming discussion of the intellectual and the artist, I do believe one can be somewhat specific about *when* those persons will truly "experience" reality in this way.

[40] Freud, *SE* 21: 75.

[41] Ibid., 21: 76.

paths that individuals may wish to pursue are the following:

> The path of quietude, science, intoxication, yoga/the mystical life, controlling one's instincts, the intellectual, the artist (retreat into illusion), the hermit, establishing love as the center of one's life, contemplation of beauty.[42]

While Freud does not claim to have provided the reader with an exhaustive list of the paths to happiness, historically and at the time he was writing, Freud saw these ten paths to happiness as the most common routes that persons follow. While to some extent this claim rests upon empirical observation for Freud, the ultimate justification for persons' pursuit of happiness is derived from a previously inferred principle of the mind, notably the pleasure principle.[43] Operating within each of our minds, Freud says:

> What decides the program of life is the pleasure principle. This principle dominates mental life from the start. There can be no doubt about its efficacy and yet its program is at loggerheads with the whole world, with the microcosm as much as with the macrocosm. There is no possibility at all of its being carried through... [44]

By identifying the ten paths to happiness and the inner, psychical principle that Freud claims lies behind this, through their conduct persons evidence a pursuit of happiness

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[42] Ibid., 21: 78-83.

[43] For the purposes of this chapter, it is not imperative that I be very clear about what Freud means by happiness. Nor do I wish to engage in the debate as to whether or not Freud thought persons are naturally hedonistic or egoistic. For an excellent analysis and overview of scholarly interpretations on these issues, see Wallwork, *Psychoanalysis and Ethics,* Ch. 5: Overview of Psychological Egoism and Ch. 6: The Pleasure Principle and Psychological Hedonism.

[44] Freud, *SE* 21: 76.

as a main goal of life.[45] It is important for the reader to note that by acknowledging this point, one-half, so to speak, of the dialectic has been established. In other words, in virtue of the structure of our mind, *all* persons seek happiness in this world. And yet, Freud goes on to say...

> It is no wonder if, under the pressure of these possibilities of suffering, men are accustomed to moderate their claims to happiness -- just as the pleasure principle itself, indeed under the influence of the external world, changed into the more modest reality principle -- if a man thinks himself happy merely to have escaped unhappiness or to have survived his suffering, and if in general the task of avoiding suffering pushes that of obtaining pleasure into the background.[46]

Admittedly, this quotation strikes one as odd when compared to Freud's previous construal of the pursuit of happiness. In the previous quotation, one has the impression that happiness is to be understood as the obtaining of positive satisfactions and not merely, as is here the case, the avoidance of suffering. The oddity of these two claims seems to hinge upon the respective roles and importance assigned to the pleasure and reality principles. On the one hand, it is the pleasure principle which has established (indeed, phylogenetically, historically and experientially) pleasure or happiness as the goal of our conduct in the external world; and yet, it is the reality principle, under the influence of the external world, which appears to limit or alters its fulfillment.

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[45] By saying that happiness is a main goal of life, I do not mean to imply that this is the only goal of life for Freud. Other ends, may be sought as well. See Wallwork, *Psychoanalysis and Ethics,* Ch. 5. .

[46] Freud, *SE* 21: 77.

The point may cause some concern to the reader. My point is that for Freud persons *invariably* come to see reality in terms of pain and misery. If, under the influence of the reality principle, persons are naturally accustomed to modify their pursuit of positive satisfactions, then my thesis would no longer hold. In a very real sense, then, my thesis can be maintained *only if* it is the case that the pleasure principle can be granted a foundational and more important role than the reality principle.

Ernest Wallwork, in his book, *Psychoanalysis and Ethics*, offers a concise and useful way of categorizing the evolution and multiple meanings of Freud's pleasure principle. The categorizations offer a useful schema for resolving the above dilemma. When exploring the plausibility of viewing Freud's ethical theory as a version of psychological hedonism, he says:

> However, those who take this position seldom probe very deeply the multiple ways in which Freud uses the concept of the pleasure principle: first, as the regulatory principle of the *primary process* of the unconscious *entire mental apparatus;* second, as the regulatory principle of the *primary process* of the unconscious or id, where it is defined in part by contradistinction to the reality principle; and third, as the ultimate goal served by the reality principle's regulation of the of *the ego's secondary processes.*[47]

Ultimately, Wallwork identifies these distinctions in order to debunk the popular portrayal of Freud as advocating psychological hedonism. Rather, Wallwork argues that Freud does believe that persons can "find satisfaction in the pursuit of non-egoistic

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[47] Wallwork, *Psychoanalysis and Ethics,* 108.

goals."[48] This thesis is made plausible by arguing that the reality principle usurps the role of the pleasure principle in the mature adult. In this way, individuals are said to endure immediate displeasure for some longer term pleasures.

This brief digression of Wallwork's thesis will enable the reader to see more clearly my interpretation of the role of the pleasure and reality principle as explained in *Civilization and Its Discontents.* In this text, Freud is clear regarding the importance and foundational role accorded to the pleasure principle in determining our wishes or striving for pleasure. These brute "desires" are never tempered or defeated by the replacement of the reality principle. Instead, Freud is saying that persons are biologically determined always to *wish for, strive after or simply want* positive pleasures. Before turning to the passage in *Civilization and Its Discontents* which suggests this view, support for my interpretation also comes from Lewis Kirshner's analysis of this topic. He says:

> In fact, the concept of the reality principle has nothing to do with objective reality, but refers simply to the ego's capacity to determine whether a given mental content derives from inner fantasy or rather, from an external perception. Fantasy-making, Freud (1911) insisted, remains a function of thought kept free from reality testing and subordinated to the pleasure principle alone.[49]

As Kirshner suggests, the reality principle need not be construed as usurping the role of the pleasure principle. Even when the reality principle is in place, at least in fantasy, persons may still be said to desire positive satisfactions. Furthermore, there is

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[48] Ibid., 109.

[49] Kirshner, *Concepts of Reality,* 223.

strong evidence that this is how Freud wants to construe the role of the pleasure principle in *Civilization and Its Discontents.* Comparing the role of the principles of the mind to the excavation of archaeological ruins, Freud there says:

> This brings us to the more general problem of preservation in the sphere of the mind. ... in mental life nothing which has once been formed can perish -- that everything is somehow, preserved and that in suitable circumstances (when, for instance, regression goes back far enough) it can once more be brought to light... Now let us, by a flight of the imagination, suppose that Rome is not a human habitation but a psychical entity with a similarly long and copious past -- an entity, that is to say, in which nothing that has once come into existence will have passed away and all the earlier phases of development continue to exist alongside the latest one... ... The fact remains that only in the mind is such a preservation of all the earlier stages alongside of the final form possible, and that we are not in a position to represent it in pictorial terms. ... We can only hold fast to the fact that is rather the rule than the exception for the past to be preserved in mental life.[50]

If one were to take this quote as one's starting point for interpretation, then, literally it is because of our phylogenetic or historical heritage that the pleasure principle is seen to persist alongside the reality principle. In addition, it is due to the fact that the pleasure principle is more primitive and hence, foundational in our nature that it's effects are not diminished and hence, still to some extent establish our search for pleasure and positive satisfactions. I do not think that it is an arbitrary point that a discussion of civilization (phenomenally shared reality) begins with this reminder that the pleasure principle is temporally, phylogenetically, that which importantly underlies

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[50] Freud, *SE* 21: 69-72.

the reality principle.

Additional evidence for the precedence that Freud grants to the pleasure principle, and by implication the fact that persons *strive* for positive satisfactions, can be found in his descriptions of the lackluster achievement of happiness in each of the ten character types. When Freud discusses the ten paths of happiness, irrespective of which of the above paths persons pursue, at some point, he believes they all will inevitably come to see *their* reality as imbued with pain and misery. Because of human nature, the various paths persons choose to find happiness will always result in their perception of reality as somehow mitigating the real satisfactions derived within this world.

Consider for example, the interesting, even if extreme, example that the case of the hermit provides for us. By a complete removal of himself from the external world and relations with men, the hermit opens himself up to private delusion; in short, Freud claims that the hermit becomes a "madman."[51] Ironically, one might think this to be the best possible path to happiness since it is a complete turning away from the two main sources of suffering, according to Freud. It is also important to note that in his description of the hermit, Freud says nothing about this person's psyche *not* being sufficiently regulated by the reality principle. Hence, even if we are to assume that the hermit is in touch with the reality principle, Freud goes on to say that in this way, the hermit becomes mad precisely because "reality is too strong for those who wish to

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[51] Ibid., 21: 81.

advance private delusions of their own."[52] Presumably, Freud is referring here to this phenomenally shared reality inclusive of our relations with others and the institutions found in society. Ironically, the hermit's attempt to reduce suffering and/or find satisfaction is destined to be met with suffering no matter which option he chooses: private delusion, or entering back into relations with others which is itself a cause of suffering. In either case, pain and misery permeate this life path.

Even when Freud explores other more "admiral paths to happiness," such as the professional life of the artist or the intellectual,[53] the overall potential level of dissatisfaction as a consequence of this life-style choice is highlighted. This is so because the very attempt to defy sources of suffering by choosing this path to happiness carries with it the paradoxical consequence that persons have actually managed to open themselves up to more actual or potential sources of suffering. I would even venture to say that the potential sources of suffering carry with them a greater amount of potential harm than if these individuals had chosen not to pursue these paths to happiness.

Evidence for the above claims comes from the following considerations: In the case of the intellectual, in choosing to pursue higher pleasures (pleasures of the mind), Freud claims that they actually run the risk of thereby loosening their "connection with reality," i.e. relations with others, with the world. Such a psychical retreat, although

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[52] Ibid.

[53] Again, I think it is important point to note that these individuals also may have passed on to acceptance of the reality principle.

offering pleasures to the few who could obtain them, says Freud, actually carries with it the unpalatable consequence that intellectuals "create no impenetrable armor against the arrows of misfortune" and as such, this lifestyle "habitually fails when the source of suffering is a person's own body." In the end, when speaking of all the advances of science, Freud concludes that "man is not happy in his God-Like character."[54]

In the case of the artist the situation is predominantly the same and even proceeds to a greater degree. Like the intellectual, the artist further loosens his connection with reality and enters into the realm of illusion.[55] Indeed, entering into illusion is the "intrinsic aim of art." The artist, like the intellectual, will come to see reality in terms of pain and misery when his/her physical nature suffers.[56]

At this point, it should be acknowledged that the only possible exception to these "paths of happiness" (which as I have tried to argue must inevitably lead to an acceptance of pain and misery), is the path of the scientist. It is the path that indeed Freud himself had chosen to follow. The scientist, according to Freud, "works with all for the good of all." In *Civilization and Its Discontents* there is scarcely a mention that this life-style could lead to pain and misery. Yet, even so, Freud says that

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[54] Freud, *SE* 21: 91-2.

[55] For a brief discussion of the worldview of the artist, see Freud, *SE 22:* 160.

[56] It is safe to say that *inevitably*, the artist or the intellectual will come to see reality this way when one considers that as physical beings we are prone to illness and will all someday die. Even if an artist or intellectual is extraordinarily healthy and will have the good fortune of a swift death, surely the mere contemplation of *possible* physical ailments is sufficient for this *kind* of person to come to see reality as imbued with pain and misery.

science is a "powerful deflection" which causes us to make light of our misery.[57]

In the end, Freud's paths to pleasure are a double-edged sword. In our search for the path to follow, and in our attempt to follow it for an attainable purpose, we are consistently led to the conclusion that...

> Life, as we find it, is too hard for us; it brings us too many pains, disappointments and impossible tasks. In order to bear it, we can not dispense with palliative measures. We can not do without auxiliary constructions. We cannot do without powerful deflections, which cause us to make light of our suffering; substitutive satisfactions, which diminish it and intoxicating substances, which make us insensitive to it.[58]

Some scholars might wish to object to this argument and claim that an individual's substitutive satisfactions *counteract* the experience of pain and misery. However, one should remember that, for Freud, substitutive satisfactions only *diminish* an already, existent, pain and misery. As I have tried to demonstrate, by citing Freud's own remarks, in pursuing any one of these paths of life, even though they may afford substitutive satisfactions, are invariably accompanied by pain and misery.

6: Summary and transition to private property

In the above section, I have tried to argue that at least in one aspect of his account of society, namely, the overall aim to which all human activity is directed (happiness), persons are bound to be greeted with the inescapable elements of pain and misery. It is because of this fact that disappointment seems invariably to accompany

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[57] Freud, *SE* 21: 92.

[58] Freud, *SE* 21: 75.

most observed paths to happiness. Like Phillip Reiff, I do believe that Freud, using the "normal environment" as his starting point for psychoanalysis, would strongly encourage persons to adopt a rather stoic stance toward life in this world.[59]

Someone might wish to object to my above interpretation by arguing that naturally my thesis would hold if one compares *this* world to some *perfect, possible world.* In other words, some might say that I am naively assuming a kind of perfect world as a backdrop against which to judge Freud's theories. Given such a perfect world as an assumption, then *of course* it would follow that by comparison to *this world*, persons must come to see reality as imbued with pain and misery. They might add that even most hedonists would admit that persons will experience some kind of pain and misery in this world.

Such an objection would have some merit. However, let me respond to this possible charge as follows. Individuals who would react to my thesis would have a stronger argument in refuting my thesis and even be more consistent if they talked about Freud himself as having appealed to a perfect criterion against which to judge human pursuits in this world. *For Freud*, this "perfect" criterion[60] lies within our actual human nature. It is the pleasure principle. In other words, viewing reality as

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[59] Phillip Reiff, *Freud: The Mind of the Moralist,* 3rd ed., (Chicago: The University of Chicago Press, 1979), 17: "Nevertheless, the connection is partly made, and from it issued that great body of pathographic writing in the drama and novel from which Freud professes to have learned far more than from academic psychology. His taste for Shakespeare -- whose characters and situations embody many of the precepts of the Stoic psychology -- is further evidence of an indirect but genuine affinity between psychoanalysis and the psychological theories of Stoicism."

[60] I use "perfect" in the sense of "absolute."

imbued with pain and misery is inevitable because of the primacy that Freud himself grants to the pleasure principle in configuring what persons wish for, strive for, etc. Of course, because it is phylogenetically the oldest, the pleasure principle is actually the standard according to which Freud himself judges the successful attainment of one's pursuit of happiness. It is the pleasure principle that in primitive times, throughout history and today has set the agenda for individual behavior.[61]

In sum, critics of my thesis would do better to attack Freud himself on this point. For, far from presupposing a perfect possible world against which to judge individual's perceptions of this world, Freud himself suggests that the criterion against which to make such judgements lies within human nature itself. In this way, the pain and misery of phenomenally shared reality would be judged to be so given our species-determined, constitutional nature and not something extrinsic to it.

But a second and more devastating objection could be levelled at the thesis of this chapter. Perhaps some readers might be willing to accept that persons pursue positive satisfactions and yet, their pursuits are inevitably thwarted in reality. Nonetheless, we are left trying to reconcile this with the following claim: "Integration in a human community is necessary before the aim of happiness can be achieved." With this comment, Freud seems to be saying that "relations with men," previously characterized as a main source of suffering, are a prerequisite to the attainment of happiness. This, indeed, is a forceful objection and one that demands a response.

In order to formulate an adequate response, I suggest that at this point we need

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[61] Freud, *SE* 13: 64, 90.

to shift our perspective from that of the individual (or, individual psychic reality) to the perspective of "reality itself" (or the nature of civilization itself). In this way, we can begin to examine one important way in which persons actually do become "integrated in a human community." Fortunately, what was true in Freud's day holds true of our present society: namely, under capitalism, private property is a societal institution around which persons form communities. By shifting our perspective to Freud's account as to why private property is a social institution, I believe that my thesis will still hold; namely, society as it is structured, with this institution of private property, further frustrates one's pursuit of pleasure. But more than this, private property reflects back to the individual a principle which is operative in his/her nature, namely the aggressive instinct. Because persons are integrated into community in this way, this still affords for the general perception of reality as imbued with pain and misery.

7: Private property

To begin the development of this second point, and thereby more fully completing the dialectic referred to earlier, let me begin by suggesting that *perhaps* one reason why external reality comes to be perceived in negative terms has to do with the role of the aggressive instinct. I believe that Freud strongly insinuates in *Civilization and Its Discontents* that it is the aggressive instinct which supersedes the erotic impulse in the formation of communities.

Although in *Civilization and Its Discontents*, Freud does not develop at length

an account about relations with others (i.e. business relations, professional, etc.), there are enough passages to suggest that the further persons are removed from the family (i.e. acquaintances, strangers, etc.) and in the event that they are not functioning as our "sexual objects," other human beings function only as objects of our hostility or aggression.[62] Outside of these general descriptions, Freud does not say much more about human modes of relating.

However, in *Civilization and Its Discontents*, Freud puts forth a polemic against communism, and in opposition defends the institution of private property. Several questions leap to mind: Why? Why this seeming digression into a socio-political question? Did Freud merely see communism as a threat and if so why?

As Freud himself notes in his later works, the inner tendency toward aggression was something that he reluctantly had to accept as part of his theory of instincts. With the continued manifestations of sadism, masochism and war-time trauma and neuroses in clinical encounters, Freud became aware of this inner tendency toward a depletion of energy -- a movement toward a state of non-being/non-existence.[63] This instinct ultimately would culminate in his theory of the Nirvana Principle. Given the subject matter of *Civilization and Its Discontents,* Freud is naturally inclined to talk about the manifestations of this death instinct in the *outer* world. And, the manifestations of this

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[62] Ibid., 21: 95-98.

[63] See Richard Wollheim. *Sigmund Freud* (New York: Cambridge University Press, 1971), 205-213, for a further analysis of the death instinct.

death instinct are aggressiveness and hostility.[64] Consider the following seemingly contradictory passages from *Civilization and Its Discontents.* When explaining the origin of his theory of the death instinct, Freud states:

> Starting from speculations on the beginning of life and from biological parallels, I drew the conclusion that, besides the instinct to preserve living substance and to join it into ever larger units, there must exist another, contrary instinct seeking to dissolve those units and to bring them back to their primaeval, inorganic state. That is to say, as well as Eros there was an instinct of death. *The phenomena of life* (emphasis added) could be explained from the concurrent or mutually opposing action of these two instincts.[65]

> The element of truth behind all this, which people are so ready to disavow, is that men are not gentle creatures who want to be loved, and who at the most can defend themselves if they are attacked; they are, on the contrary, creatures among whose instinctual endowments is to be reckoned a powerful share of aggressiveness. As a result, their neighbor is for them not only a potential helper or sexual object, but also someone who tempts them to satisfy their aggressiveness on him, to exploit his capacity for work without compensation, to use him sexually without his consent, to seize his possessions, to humiliate him. *Homo Homini Lupus.* Who, in the face of *all his experience of life and of history,*(emphasis added) will have the courage to dispute this assertion?[66]

> The communists believe that they have found the path to

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[64] It is important to note that there is some ambivalence as to how Freud talks about the death instinct in his later works. For example, see the editor's introduction in Freud, *SE* 6:6, where it is claimed that in *The Ego and the Id,* "the aggressive instinct was still something secondary, derived from the primary self-destructive death instinct." This is still true of the present work, even though here, the stress is upon the death instinct's manifestations *outward.*

[65] Freud, *SE* 21: 118-119.

[66] Ibid., 21: 111.

> deliverance from our evils. According to them, *man is good and is well-disposed* (emphasis added) to his neighbor; but the institution of private property has corrupted his nature... If private property were abolished, all wealth held in common, and everyone allowed to share in the enjoyment of it, ill-will and hostility would disappear among men. [Freud's response:] ... I am able to recognize that the psychological premisses on which the system is based are an *untenable illusion* (emphasis added).[67]

As noted in the first section, when considering the phenomenon of life, Freud quite often paints it in terms of a struggle between Eros and Death. Given these two instincts, it would seems as if there are two viable ways in which persons naturally may be led to integrate in human communities. Both would of course represent these natural drives. To be fair to Freud's theory, let us consider how our natural erotic and libidinal interests forge this integration in society. In *Civilization and Its Discontents,* Freud claims that the outward manifestations of the erotic instinct are: "the binding double individuals" in terms of love and marriage. Such individuals are said to be "libidinally satisfied in themselves."[68] Yet, in such a pure form, Freud proceeds to say that "this desirable state of things does not, and never did, exist."[69] Rather, at least in outer reality, it is civilization that forces the continued expression of the erotic instinct *in a much modified way* by means of aim-inhibited libido; precisely so as "to strengthen the communal bond by relations of friendship."[70] For the aims for which

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[67] Ibid., 21: 112-113.

[68] Ibid., 21: 108.

[69] Ibid.

[70] Ibid., 21: 109.

we truly strive, namely sexual gratification, society imposes "a restriction upon sexual life" that "is unavoidable."[71]

In the canvas of reality as we find it, Freud tells us that the erotic instinct only exists in a modified way. How then, does this view get reconciled with his other claim that "love and necessity are the parents of civilization?"[72] I would suggest that such a claim is to be construed *as stated.* What accounts for the *origin* of society is indeed the erotic instinct; however, society as it exists today (and as it has historically developed) allows for only this *modified expression* of the erotic instinct. I think this claim is especially important when compared and contrasted with Freud's developmental account of the aggressive instinct. He says:

> (Aggressiveness)... reigned almost without limit in primitive times, when property was still very scanty, and it already shows itself in the nursery almost before property has given up its primal, anal form; *it forms the basis of every relation of affection and love among people* (emphasis added).[73]

The above quotation is interesting for two reasons: First, by claiming that "it forms," *(present tense)* I take Freud to be saying that still, in our present-day reality, the aggressive instinct is allowed full *(and not modified)* expression. But more interesting, one should note the foundational dependence that Freud seemingly grants to the aggressive instinct. For, it is this instinct which acts as the basis for the very expression of the (modified) erotic interests (friendship, affection, etc.) in society. It is

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[71] Ibid.

[72] Ibid., 21: 101.

[73] Ibid., 21: 113.

precisely the aggressive instinct that is said to give life to the libidinal ties that now exist. In fact, as we shall see in the next section, it is religion, society's delusion, that fosters modified and inauthentic expressions of our instincts.

Having worked through the first of the above series of quotations, it is now possible to understand fully the nature of the subsequent two cited passages. In the second and third citations, Freud is still speaking about reality as we find it; yet, in these passages, Freud sounds more like a philosopher than a psychologist advocating psychoanalytic theory. There is something very weighty about those passages, for Freud clearly seems to be making some general claims about human nature that are specifically *not* to be construed as a phase (among many) of individual development. Rather, he seems to be making claims as to what a human being's innermost essence is really like (even if the reality principle regulates the person's psyche). When all is said and done, not only is it apparent that my thesis holds, but even more boldly, in this passage Freud appears to be saying that persons essentially *are* aggressive and hostile creatures. Is it no wonder, then, that private property is the logical and necessary expression of this?

What seems to be even more interesting about the second quotation is that typical behavioral expressions related to the erotic instinct (sex and affection), seem to be tied intimately to human beings' aggressive nature. For, one's neighbor tempts human beings and are seen ultimately as objects of sexual gratification. The third citation which contains Freud's critique of the communist position on human nature only serves to buttress this point. Theories of human nature which claim that "men by

nature are essentially good and well-disposed to their neighbors," seem to be as unreal as the claims of religion, according to Freud. Such theories overlook the fundamental presence and strength, indeed the "indestructible feature of human nature; namely aggression.

In the end, and as I have tried to show, Freud's polemic against communism's notion of communal property contains within it far more than a mere critique of political ideology. Private property, as a social institution is a constant reminder of the ultimate hostility of persons. Indeed, perhaps "integration in a human community is a necessary prerequisite of happiness," however, the integration itself reinforces a perception of reality in terms of pain and misery. In the end, Freud's discussion of private property is not simply a necessary consequence of his theory of human nature, nor of an internal struggle between two opposing instincts; but rather, it is our culture's symbol of the pain and misery of which we must endure in this world.

8: Considerations of religion

A brief consideration of the role of religion seems to be necessary before concluding this chapter. Religion, in Freud's view, is an avenue which one could choose in order to escape the perception -- perhaps the feeling -- of viewing their environment in the way that I have portrayed it thus far. For Freud, religion is one of the main "institutions" which is present in almost every culture. It also is an aspect of culture that Freud deals with extensively in his later works. Most often, people focus on his critical comments towards religion. There certainly are an abundance of these and it is clear that it is one of Freud's great hopes that in the battle between the

scientific *weltanschauung* and the religious, the former will be victorious. For this reason, this chapter would be incomplete without at least addressing the role that religion plays in society.

Thus far, I have been painting outer reality as imbued with pain and misery. Both of these features are inherent in society's institutions and this is so because of the psychological nature of human beings (i.e. the dominance of the pleasure principle, and the aggressive instinct). However, what I wish the reader to note in this section is Freud's view that religious believers are those who have not successfully passed through an important individual stage of development. In addition, even though religion may afford them an escape from perceiving reality as imbued with pain and misery, it is clearly stated that this is not the path for individuals, let alone for society at large, to pursue.

Religious believers, for Freud, are those persons who still are truly fixated at a phase of infantile development, namely the Oedipal Complex.[74] These individuals have not moved on to acceptance of the reality principle. Freud notes repeatedly, that a mere stage of development (and not an innate biological *principle* of inner psychic reality) namely, the Oedipal Complex has actually and perversely been manifested in civilization by means of religion. A vast majority of people subscribe to some kind of religious belief and look to a Godhead both for protection and ethical precepts. Religion offers a primitive kind of retreat from the pain and suffering inherent in civilization. However, according to Freud, religion offers a feeble path toward social

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[74] Ibid., 21: 43.

progress and better individual prospects for the attainment of happiness. For Freud, all religion can afford is a further retreat into "group delusion and obsessional neurosis." Such a retreat is nothing less than an illusion. In a very real sense, religion is the false (primitive) promise of happiness that Freud actually wants us to avoid.

One might very well wonder why Freud wants individuals so desperately to avoid the traps of religion. This is especially true when Freud himself claims that one may embrace religion as a narcotic and hence, as a deflection against negative perceptions of reality.[75] This is especially curious when one considers that Freud truly seems to *want* persons to perceive reality in more positive terms. Optimistically, Freud says that this can only occur in "a distant, distant future, but probably not in an infinitely distant one."[76]

Whether or not, Freud himself completely understood how this perception of reality could be construed in more positive terms is open to speculation. At times, he strongly suggests that it is pursuing the path of science that affords most individuals their best hope.[77] Even so, there are other passages in which Freud expresses doubt that this path can afford a lessening of this vision of reality.[78] However, Freud is

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[75] Freud, *SE* 21: 49, 75.

[76] Freud, *SE* 21: 53.

[77] See Freud, *SE* 22: 158-182 and *SE* 21: 53 In order to be a follower of the scientific weltanschauung one must "listen to the soft voice of the intellect," and "adhering to reason and experience."

[78] Note Freud's honesty in *SE* 21: 53-54, where he repeatedly claims that the scientific weltanschauung *might itself* provide civilization with yet another illusion. However, it is clear that these are far preferable than those religion affords us.

uncompromising regarding the following issues: 1) society will not be happier by retreating into untamed expression of its developmental impulses, namely the Oedipal Complex; 2) "group agreement" is not the criterion by which to judge what is objectively real nor does it afford the most successful path to happiness; and 3) Religion only offers a *seeming* path to happiness, yet, like a narcotic, it really only opens up the door to more potential pain and misery in the end.

Perhaps the sole conclusion to be drawn from the above considerations is that it is only by adopting a "stoic resignation" to this present life, that there will be even a glimmer of hope for founding a society which will allow for "a love of man and a decrease of suffering."

Ironically and in conclusion, I think it is by means of Freud's thoroughgoing critique of religion that we actually discover a rather optimistic and pragmatic theorist. For Freud, life is certainly not forevermore destined to be perceived as consisting of pain and misery. There is hope that we can live in a world where there exists a "love of man and a decrease in suffering." However, this would require modifications in human nature that could, in time, be expressed outwardly in civilization.

9: Conclusion

In this chapter, I have attempted to take seriously Freud's claim that a vision of the "normal environment" functions as the ultimate starting point for the *practice* of psychoanalysis. Having presented some evidence to demonstrate that Freud himself thought that the phenomenal view of reality is imbued with pain and misery, I hope to

have recast and enlarged a proper foundation by which to consider the assumptions behind the practice of psychoanalysis.

While it would be more convincing to conclude this chapter by having demonstrated how Freud himself made use of this vision of reality in his clinical cases, it is unfortunate that his case studies shed minimal light in demonstrating the force of this claim. Rather, the majority of Freud's clinical cases read as the presentation of mere facts. Very little of *his interpretation of the normal environment* is afforded to the reader. One can only surmise what was actually conveyed to the analysand during and as a consequence of treatment by Freud himself. For these reasons, I can only conclude this chapter by offering some final suggestions to present commentators who purport to assess what the role of the psychoanalyst *is* or *should be.*

First, I would urge scholars to abandon viewing the role of the psychoanalyst as "value-neutral." My aforementioned criticisms of this view suggest that viewing *any* form of therapy as lacking a normative dimension is but a mere pipe-dream. In this chapter, I have attempted to demonstrate that psychoanalysis itself presupposes a distinct and value-laden view of reality. Once one has considered the values implicit within the view of reality that psychoanalysis ultimately adopts, this should be sufficient to see that any non-normative practice of psychoanalysis simply can not be considered.

Second, I would advocate that hermeneuticians begin to take seriously what the aged Freud had to say after his many years of treating a variety of patients.

Hermeneuticans implicitly and subtly would have us believe that *both* the analysand and analyst are learning new "truths" about reality itself after treatment in therapy. Freud's final works demonstrate that rather than consistently learning new truths, the *analyst* is more persuasively led to the adoption of a unified and consistent vision of reality.

Finally, with respect to those who portray analysts as advocating values that are ultimately derived from systems extrinsic to the theory itself, I would simply ask: how is it possible to justify, let us say, a religious value in terms of psychoanalysis? Freud himself would most likely portray such a justification as stemming from a stunted nature -- a psychoanalyst trapped at an early stage of human development.

It is hoped that this interpretation -- for it is only an interpretation -- may be of some constructive use to the contemporary discussion of Freud's ideas regarding the role of the analyst and how this may be said to impact, in a very real sense, the client who is treated.

CHAPTER TWO

HARRY STACK SULLIVAN'S INTERPERSONAL THEORY OF PSYCHIATRY

Since his death in 1949, much has been made about both the person and the theories of American psychiatrist, Harry Stack Sullivan. Famed during his lifetime for his novel clinical work with male schizophrenics, today Sullivan is widely recognized as the founder of the Interpersonal Theory of Psychiatry. Because Interpersonal Theory is presently a main theoretical orientation for practicing psychotherapists,[1] the contributions of Harry Stack Sullivan are a suitable and an important focus for this dissertation.

Background

Sullivan's Interpersonal Theory of Psychiatry (ITP) developed from his work as a clinician. Born in 1892 in New York, he managed to put himself through medical school. His interest in psychiatry emerged when he was assigned to work under the supervision of psychiatrist William Alanson White at St. Elizabeth's Hospital in

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[1] Council for the National Register of Health Service Providers in Psychology, *National Register*, I-13, identifies six "primary" theoretical orientations that psychologists may use to identify their practice. These are: Behavioral, Cognitive/ Cognitive Behavioral, Existential/Humanistic, Interpersonal, Psychodynamic, Social Learning Systems.

Washington, D.C. During those years, White encouraged Sullivan's growing interest in psychiatry.[2] After leaving St. Elizabeth's, Sullivan went to Sheppard and Enoch Pratt Hospital in Towson, Maryland where he began a ward for research in male schizophrenia. By the end of the decade, Sullivan began to formulate many of the ideas of his Interpersonal Theory of Psychiatry.

In the 1930's, Sullivan moved to New York City and began a private practice. He continued to work with schizophrenics, but also became interested in treating obsessional neurotics. His desire to work in the clinical setting never waned and in 1937, he became affiliated with the Chestnut Lodge Sanitarium in Rockville, Maryland. While there, he did much supervisory work and held informal conversations with colleagues and students -- much of which was to become the basis of later books published posthumously by colleagues and friends. Today, six texts in all constitute the Sullivan corpus. Interestingly, while Sullivan published many articles and later became the first editor of the journal, *Psychiatry*, he reluctantly authorized the publication of only one book during his lifetime, *Conceptions of Modern Psychiatry.* Apparently, he was never satisfied with the content nor the exposition of his work.

Toward the end of his life, Sullivan became actively involved in issues of world mental health. He participated in conferences with social scientists and other

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[2] Harry Stack Sullivan, *Conceptions of Modern Psychiatry,* (New York: W.W. Norton & Company, 1953), 177. Sullivan was later to acknowledge that White, Adolf Meyer and Freud were the three figures who most considerably influenced his thinking.

psychiatrists both in the United States and abroad. While in Paris in 1949, Sullivan died of a cerebral hemhorrage.[3]

Much of the secondary literature that one finds on ITP has been written by Sullivan's colleagues and friends. Their goal is to clarify the main tenets of ITP in "nontechnical and concise" language.[4] Other literature on Sullivan recognizes the importance of his work, but tends to explain his theory as a mere extension and complement to Freud's psychoanalysis.[5] Irrespective of their purpose, almost everyone who comments on Sullivan's thoughts tends to remark at some point on the difficulty of interpreting his theory. His many neologisms and awkward writing style makes any commentary on Sullivan a difficult endeavor.[6]

In this chapter, we will consider the philosophical assumptions of ITP with the intent of uncovering the normative assumptions of this school of thought. Having worked through Sullivan's writings -- replete with his detailed accounts of the development of the self, his categories of mental illness, his long account of the psychiatric interview and goals of treatment -- it is my belief that the ethic of ITP has

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[3] David Lawson. *The Teaching of Values: From Ethical Idealism to Social Psychology: Adler, Dewey, Sullivan, Fromm* (Montreal: McGill University, 1970), 59-60.

[4] Patrick Mullahy, ed. *The Contributions of Harry Stack Sullivan, A Symposium on Interpersonal Theory in Psychiatry and Social Science* (Washington, D.C.: Science House, 1967), 5.

[5] J.A.C. Brown. *Freud and the Post-Freudians* (London: Penguin Books, 1961), 165.

[6] Mullahy, *Contributions,* 5.

many similarities to the moral theory of eighteenth century Scottish Enlightenment philosopher, David Hume.[7] By the end of this chapter, I hope to demonstrate that the main goal of Sullivan's ITP is for persons to behave as members of their "society" behave. Engaging in socially acceptable actions creates feelings of security within the individual who performs them. Nonetheless, it is one's inner character (Hume) or personality (Sullivan) that ultimately "determines"[8] how persons will behave. Saying this in another way, mental health, for Sullivan, is empirically observed in external actions; however, these actions are causally tied to one's personality. The latter is only known through inference.

The ethical theory in ITP has some interesting implications for understanding the role of the psychiatrist and how he treats "mentally unhealthy" persons. According to ITP, it is the psychiatrist who claims to have the *ability* to "affect" personality. Changes in personality necessarily imply changes in *living.* It is my contention that in ITP how the client *lives* his/her life is of paramount importance.

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[7] The reader should note that by forging a parallel between Hume's moral theory and Sullivan's ITP, I am in no way undermining the thesis of this dissertation. In this chapter, I will not argue that Sullivan's ITP *is* or *should be* a moral sense theory. Rather, I invoke the moral theory of David Hume because it is useful in highlighting where the normative assumptions are (and what their content is) in Sullivan's ITP.

[8] The word "determinism" has multiple meanings. As used in this context, it is not intended to deny "free will." Most scholars agree that Hume is a soft-determinist; namely, that a person is "free" to form their character; but once established, actions are "caused" by character. There is good evidence, as I will show that Sullivan implicitly adheres to this view. For an exploration of this topic as it pertains to Sullivan's ITP, see Patrick Mullahy. "Will, Choice & Ends," *Psychiatry,* vol. 12 (1949):379-386.

Because of this, it seems to me that Sullivan must concede that what is of central importance to the psychiatrist's expertise is his understanding of the social norms of culture/society. As a consequence of this view, a successful application of ITP depends minimally on the "medical" expertise of the psychiatrist. This chapter will conclude with some further thoughts on what this thesis means for understanding the role of the psychiatrist and the normative goals of treatment that ITP may be said to have for the client.

In order to illustrate the above thesis, this chapter will assume the following structure:

1) What is the interpersonal theory of psychiatry?: historical background
2) Development of the self: basic needs
3) Why the "need for security?": the role of experience in the development of the self
4) Sullivan's conception of mental illness
5) The role of the psychiatrist: the therapeutic encounter
6) The goals of therapy

1) What is the interpersonal theory of psychiatry?: historical background

Perhaps the best place to begin is with the text that "represents the last complete statement which Sullivan made of his conceptions of psychiatry."[9] In *The Interpersonal Theory of Psychiatry*, consisting of a series of lectures that Sullivan gave at the Washington School of Psychiatry in 1946-7, he defines its practice as follows:

One needs to consider psychiatry as an expanding *science*,

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[9] Harry Stack Sullivan. *The Interpersonal Theory of Psychiatry,* ed. Helen Swick Perry and Mary Ladd Gawel, (New York: W.W. Norton & Company, 1953), vii.

> (emphasis added) concerned with the kinds of events or processes in which the psychiatrist participates while being an observant psychiatrist. The knowledge does not arise from a special, kind of data but from the characteristic or *operations in which the psychiatrist participates* (emphasis added). The actions or operations from which psychiatric information is derived are events in *interpersonal fields* (emphasis added) which include the psychiatrist. The events which contribute information for the development of psychiatry and psychiatric theory are events in which the psychiatrist participates as a psychiatrist, the ones which are scientifically important are those which are accompanied by conceptual schematizations or intelligent formulations which are communicable. These, in turn, are those actions or operations which are relatively precise and explicit -- with nothing significant left equivocal or ambiguous.[10]

In the spirit of Freud who preceded him, Sullivan conceives of psychiatry as a science.[11] Like Freud, Sullivan was trained in psychoanalysis and never fully abandoned his belief in traditional categories of mental illness. He also viewed the psychiatrist as possessing the requisite "expertise" to remedy these ailments. However, unlike Freud, the science which he refers to is more broadly and appropriately construed as a social science. I would argue that contrary to what some commentators seem to suggest, Sullivan never sharply distinguished between viewing psychiatry as

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[10] Ibid., 13. The italicized words are intended to highlight what is both novel about Sullivan's ITP as well as to guide this present discussion in tracing the debt that his theory owes to previous scholars.

[11] There is a passage in which Sullivan appears to contradict this view and says that psychiatry may be conceived of as a therapeutic art. See Sullivan, *Conceptions of Modern Psychiatry,* 173. However, given the context in which he is speaking about psychiatry, I do not think that undermines his view that psychiatry is ultimately to be conceived of as a science. In that passage, he expresses concern about how rapidly the social order is changing in American society and as a result, so too the practice of the psychiatrist may have to change. It is in that context in which he equates psychiatry with being an art.

an "objective" science on the one hand, and a social science, on the other.[12] On the contrary, what makes ITP a novel theory is that it makes psychiatry *be* a social science.[13] Sullivan is insistent that psychiatrists, just like social scientists, have the same object of study insofar as they "deal with living."[14] Moreover, psychiatrists can only understand these problems if they understand how in general, persons in society behave.

From a historical point of view, conceiving of psychiatry as a social science demonstrates Sullivan's theoretical alignment with the Chicago School of Sociology, in particular with the work of George Herbert Mead and W.I. Thomas.[15] Sullivan, like Mead, believed that social psychology involves "an account of the development of the self on the basis of reflected appraisals from others and the learning of roles which one undertook to live or 'which live one.'"[16] If the subject of psychiatry is the ailing self and the self is formed by reflected appraisals of others, then in practice, psychiatry

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[12] For an example, see: Mullahy, *Contributions,* 5.

[13] See Helen Perry Swick. *Psychiatrist of America: The Life of Harry Stack Sullivan,* (Cambridge, MA: Harvard University Press), 1982, 258, for an excellent sampling of Sullivan's own and friends' remarks on this claim. Sullivan is claimed to have said in 1930: "I think that it would be a very difficult proposition to show wherein psychiatry is more of a medical than a social science," and friend and colleague, Dorothy Blitsen says: "Harry Stack Sullivan was a social scientist whose specialty was psychiatry."

[14] Ibid., 3.

[15] Perry, *Psychiatrist of America,* Chapter 29. It is important to remember that this school was significantly influenced by the pragmatism and instrumentalism of John Dewey.

[16] Sullivan, *Interpersonal Theory,* 5.

must be reflective of social reality. Edward Sapir, also a member of this school and long-time friend of Sullivan, illustrates this fusion of disciplines and subject matter when addressing both psychiatrists and cultural anthropologists. He says:

> We are not, therefore, to begin with a simple contrast between social patterns and individual behavior, whether normal or abnormal, but we are, rather, to ask what is the meaning of culture in terms of individual behavior and whether the individual can, in a sense be looked upon as the effective carrier of the culture of his group.... we then discover the field of social psychology which is not a whit more social than it is individual and which is, or should be, the mother science of both the cultural anthropologist and the psychiatrist.[17]

Just as the cultural anthropologist can not study his subject neutrally and impersonally; so too, the psychiatrist must reject "the fatal fallacy" of viewing human relations as capable of being analyzed objectively.[18] The ITP psychiatrist must, by contrast, engage in "participant observation." While this is by no means an obvious concept, in simple terms, this means that the psychiatrist confines himself to an area of study, namely, the field of "human relations" between himself and the patient. Within this field of operations -- indeed, only in this reciprocal area of relations -- data are elicited for study. This concept will be treated at greater length in forthcoming sections of this chapter; however, what is important to note here is the novel subject matter of ITP's investigation. Focusing as it does on the participant observation of the psychiatrist, ITP takes an important move away from the supposed objectivity,

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[17] Edward Sapir. *Selected Writings of Edward Sapir in Language, Culture and Personality*, ed. by David G. Mandelbaum, (Berkeley: University of California Press, 1949), 513.

[18] Ibid., 576.

impersonality and neutrality of psychoanalysis, so advocated by Freud. This theoretical commitment will be shown to have utmost importance as this chapter proceeds.

2) Development of the self: basic needs

Having provided the reader with a general description of ITP and an explanation of its theoretical ties, let us begin with the most important philosophical assumption of Sullivan's theory, namely with an account of the development of the self. Sullivan himself claims that we can not begin to even understand psychiatry, let alone his version of it, "...unless we know how everyone comes to be at chronologic adulthood. It is only in this way that we can then understand problems in living."[19] It is primarily this theme which Sullivan spent much time exploring in his earlier works, notably, *Personal Psychopathology* and *Conceptions of Modern Psychiatry.* For Sullivan, ITP must begin with an account of individual development, because it foretells what this version of psychiatry intends to accomplish both as a discipline and in practice.

Sullivan begins his account of the self with an exploration of "needs/ motivational systems." Individuals are said to have "natural needs," such as hunger and thirst, that demand fulfillment because of physico-chemical nature. Sullivan repeatedly claims that "persons are animals who grow up solely for the purpose of

[19] Sullivan, *Interpersonal Theory*, 4.

living with other people in some sort of social organization."[20] Additionally, developing infants demonstrate a basic need for tenderness. This need for tenderness or security[21] functions as the defining characteristic of human beings. Even at this early stage of development, tenderness is so important, that its lack will inevitably cause "disorders in living" (or, as we will see in the next section, mental illness). In other words, humans only become "human," in Sullivan's eyes, by having their need for tenderness satisfied. As such, it is accorded foundational importance in his theory and has broad implications for the practice of ITP. The most important of these implications are identified below.

First, for Sullivan the basic need for security can only be satisfied by and through another human being(s). During infancy, this is typically the mother. To have this need satisfied requires that one be in an "interpersonal field." Mullahy provides an excellent and comprehensive definition of this concept. He says:

> Sullivan thought that interpersonal situations imply something more than the presence of two people somewhere. The two people are *involved* with each other-- they are integrated. An interpersonal situation is brought into being by, held together by, and the course of their events or processes are to a certain extent determined by, something in the two people which is *reciprocal*, the manifestations of which coincide approximately in time.[22]

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[20] Ibid., 5.

[21] Tenderness is the form of security demonstrated in infancy; security is the generic term that Sullivan uses to say how this basic need is satisfied throughout the course of one's life.

[22] Patrick Mullahy and Menachem Melinek. *Interpersonal Psychiatry*. (New York: Spectrum Publications, 1983), 199.

At some point, in the development of the infant, one learns to satisfy one's own bodily needs of hunger, thirst, etc.; however, tenderness is immune to being satisfied in isolation. The notion of an interpersonal field has a twofold importance: a) from the moment of birth, the infant's basic need for tenderness is satisfied by the mothering person and at this very moment, the socialization/humanization of the self begins and b) as the self matures, through the phases of the juvenile period and into adulthood, this basic need for tenderness persists. In the former phase, it is recognized in the need for "chums" and in the latter, it evolves into the need for intimacy and is satisfied with and through a significant other.

Second, what is important to recognize in the above account is Sullivan's view that the satisfaction of the need for tenderness is somehow broader and more important than the satisfaction of bodily needs. Sullivan claims that if the need for tenderness is not satisfied, all other needs are thereby frustrated.[23] Presumably, he thinks this is the case because "anxiety," (defined as the lack of security) unlike our bodily needs, is not confined to a specific zone of interaction/body part that requires satisfaction;" but rather, it has "nothing specific about it."[24] And again, because the satisfaction of the need for tenderness is facilitated by and through another or is frustrated by the feeling of anxiety that others cause us, Sullivan claims that these states are descriptive of the interpersonal situation. The symbiotic nature of this feeling of anxiety or the establishment of security is crucial to note at this point; for in a very real sense, it

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[23] Sullivan, *Interpersonal*, 42, 95.

[24] Ibid., 42.

foreshadows the *kind* of therapeutic encounter that is encouraged in ITP.[25]

Finally, according to Sullivan, the securing of tenderness or its lack (anxiety) promotes a growing capacity of "recall" and "foresight" within the developing self. Clearly, the infant develops by learning to engage in those actions which promote tenderness and eliminate anxiety. It would not be completely off the mark to suggest that Sullivan's entire theory of the growth of the self is reduced to this basic point: the better one is at securing satisfactions from another and thereby eliminating anxiety, the more healthy or better adjusted in society she will be.

At this point, I would like to forge the parallel that I stated in the introduction of this chapter, namely the similarity between Hume's moral sense theory and Sullivan's ITP. In both method and point, it seems to me that Sullivan modernizes Hume's conception of sympathy as developed in *The Treatise of Human Nature.* What Sullivan conceives of as the "need for tenderness," and traces back to infancy, Hume referred to as a "natural propensity" found in all individuals. While neither theorist would claim these are observable in themselves, both would agree that they can be *inferred* from their effects. Hence, both Sullivan and Hume adopt an empirical method to establish their views.[26] The following quotes from Hume's, *Treatise,*

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[25] What will later be shown (section 4) is that the therapist-client relationship is characterized precisely in these terms. Any interview situation for Sullivan is always characterized by "anxiety." Yet, both parties experience anxiety which is in search of security. See Sullivan, *The Psychiatric Interview,* 94.

[26] For an illustration of the empirical approach in Sullivan's work, see: Lawson, *Teaching of Values*, 60-1.

illustrate this similarity. He says:

> No quality of human nature is more remarkable, both in itself and in its consequences, than that propensity we have to sympathize with others, and to receive by communication their inclinations and sentiments, however different from, or even contrary to our own. This is not only conspicuous in children, who implicitly embrace every opinion propos'd to them; but also in men of the greatest judgment and understanding...[27]

> When any affection is infus'd by sympathy, it is at first known only by its effects, and by those external signs in the countenance and conversation, which convey an idea of it. This idea is presently converted into an impression, and acquires such a degree of force and vivacity, as to become the very passion itself, and produce an equal emotion, as any original affection.[28]

One last implication needs to be addressed before moving on to the next section, The self system, which will further develop this parallel between the foundational role that Hume grants to the account of sympathy and Sullivan's idea of one's basic "need" for tenderness. Since a "perfect sense of tenderness" or "a complete sense of anxiety" are never experienced, the self develops in such a way so as to adjust or bring about an equilibrium between these two states. This resulting balance will ultimately produce the "self-system" and this leads us to the next topic.

3) Why the "need for security?" The role of experience in the development of the self-system and individual personality

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[27] Hume, *Treatise*, II, xi, 316.

[28] Ibid., 317.

Having demonstrated that satisfying the need for security allows the self to grow and develop, one might still be wondering *why* Sullivan granted such a foundational role to this need in his theory. In order to respond adequately to this question, two issues need to be considered, namely: 1) What *is* the nature of human experience, according to Sullivan? Only by addressing this question can one come to an understanding of *why* and *how* "the self" develops at all. But, 2) answering this question will involve the more complicated task of discerning what the "self" really is according to Sullivan. Anyone who glances even superficially at the Sullivan corpus will discover that he makes use of a wide-array of terms to describe the self -- "self-system," "self-dynamism," "persons," "personification," and "personalities." What I will argue, is that there is a sharp distinction between what Sullivan calls the self-system ("an explanatory concept and a quasi-entity"[29]) and one's personality ("a hypothetical, a merely possible entity."[30]) The importance that this has for the practice of therapy is that it is only "personalities" which are the proper focus of treatment. Only by affecting one's personality can the ITP psychiatrist hope to correct behavioral problems, otherwise called, "disorders in living" (mental unhealth/illness). Yet again, I will argue that in this respect Sullivan's ITP is decidedly Humean in its approach. For, according to Hume, one's character is also formed by and through society; and it is one's character that is causally connected to behavior. However, establishing this point will naturally lead us to the dissimilarities or, more

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[29] Sullivan, *Interpersonal*, 167.

[30] Ibid.

appropriately, the novel aspects of Sullivan's theory in comparison to Hume. Sullivan, in contrast to Hume, will focus his discussion on "unhealthy" personalities and the role that the psychiatrist plays in remedying these.

Few commentators writing on ITP have expressed how it is that Sullivan's conception of human experience acts as the ultimate justification for the existence of the self-system.[31] In his *Interpersonal Theory of Psychiatry,* there is an interesting passage entitled, "The Necessary and Unfortunate Aspects of the Self System." Consider the following claim:

> The origin of the self-system can be said to rest on the *irrational* character of culture or, more specifically, *society* (emphasis added). Were it not for the fact that a great many prescribed ways of doing things *have* to be lived up to, in order that one shall maintain workable, profitable, satisfactory relations with his fellows; or were the prescriptions for the types of behavior in carrying on relations with one's fellows perfectly rational -- then, for all I know, there would *not* be involved in the course of becoming a person, anything like the self-system that we *always* encounter (emphasis added).[32]

What is curious about the above paragraph is the way in which Sullivan seems to characterize society or cultures in general. Implicitly, the characteristics of group living are such that they involve an ineliminable "irrational" component. It is this idea that group living *is* somehow irrational, in its very nature, that acts as the ultimate justification for the self-system. The very act of living together, intrinsically and inevitably frustrates the possibility of completely satisfying the individual's need for

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[31] Ibid., 165. "The self-system is thus an organization of educative experience called into being by the necessity to avoid or minimize incidents of anxiety."

[32] Ibid., 168.

security. So much is this the case that when Sullivan contemplates human development in a purportedly 'ideal" culture, he claims: "But even at that, I believe that a human being without a self-system is beyond imagination." Given his empirical approach, the irrationality of society is evidenced in a variety of ways: through societal prescriptions, social rules, norms, in the mere expectations others have of us. Yet, in spite of its irrationality, paradoxically, it is society itself that allows human beings to become quite literally human.[33]

Having seen that it is society which acts as the ultimate justification for the growth and development of the self-system, let us now turn our attention to the second question: What is the "self" according to Sullivan? I wish to suggest that there are two intrinsic aspects of the self. First, there is a self-system that I believe represents the permanent core of the self. This aspect of the self can only be known by inference and is not the proper object of treatment in the therapeutic encounter. But, the *kind* of self-system one develops is causally related to the second aspect of the self, namely, personality. Personality, too is known by inference; but personality is linked by necessity to behavior.

Sullivan postulates that the self-system develops by organizing experience in the following three ways. An outline of these *kinds of experience* is listed below so as to indicate what levels of experience the psychiatrist postulates in the development of the self-system. However, it is only the third kind of experience that is both evident

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[33] IT psychotherapists are ironically, as it will be shown in the next section, practitioners and experts of this irrationality.

and operative in the confines of therapy.

> - Prototaxic Experience: is the first kind of experience that the infant has; the infant experiences reality as an undifferentiated "cosmic" totality
> - Parataxic Experience: The wholeness of experience is broken into parts, but still not arranged in a logical fashion
> - Syntaxic Experience: when the child learns the consensually validated meaning of language.[34]

A discussion of Sullivan's notion of experience would not be complete without at least mentioning the above three modes of experience. For these are the ways, known by inference, that *all* human beings develop a self-system.

As the infant moves through these various levels of experience, the infant is said to learn; for "learning" by definition is nothing more than the "organization of experience." This learning is brought about by means of an "other," or the mothering one, and is accomplished according to the gradient of anxiety.[35] In this way, the self develops and learns to organize experience by means of what either diminishes anxiety and/or increases security.[36]

Once the infant begins to organize experience at the syntaxic level, the self-system is said to be firmly established and the transition from infancy to childhood

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[34] Ibid., 28.

[35] Ibid., 153.

[36] While it is tempting to suspect that Sullivan is subtly advocating a kind of hedonistic ethic, I urge the reader not to adopt this view. One must remember that the self-system aims at an equilibrium between anxiety and tenderness; however, the feeling of security itself (construed of in terms of pleasure/happiness), is an unrealistic goal. The presence of anxiety mitigates the possibility that one could achieve pure pleasure/happiness. And if anxiety is always present (and given the interpersonal nature of anxiety) -- this just basically says that human relations aren't that conducive to wholly satisfying the individual.

occurs. When the infant begins to be educated in a consensually validated way, specifically in terms of a language, acculturation is said to begin. The manipulation of signs and symbols in meaningful ways with others, for Sullivan, is the most overt empirical example of our uniquely "human" experience. These broad categories of experience also serve as markers for Sullivan's more specific analysis of general patterns of experience for the development of the self.

While all self-systems grow and develop according to these kinds of experience, not all infants receive the same kinds of displays of affection. For this reason, the self-system develops along the lines of whether its primary expressions of tenderness were either malevolent or tender. Mullahy describes this as follows:

> The undergoing of tenderness, that is, the experience of beneficent activities of the mothering one, in turn promotes in the development in the infant and child an active interest in being tender as is manifested in playing with dolls, etc. But subsequent very unfortunate experience may compel the youngster to dissociate his tender impulses or to disintegrate them.[37]

What *kind* of expressions of tenderness the infant has been shown will determine to a large extent what *kind* of personality one is to develop.[38] For this reason, and as stated earlier, Sullivan calls "personality" a hypothetical (possible entity) which is formed against the permanent, but unobservable and untreatable "self system." He

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[37] Mullahy, *Contributions,* 45.

[38] See, Sullivan, *Conceptions,* 21-22: "In other words, it (the self-system) is self-perpetuating, if you please, tends very strongly to maintain the direction and characteristics which it was given in infancy and childhood." And again, "And so the unhappy child who grows up without love will have a self-dynamism which shows great capacity for finding fault with others and, by the same token, with himself."

says: "Personality is the relatively enduring pattern of recurrent interpersonal situations which characterizes a human life.[39]

Personalities begin to emerge when one begins to organize experience syntactically. Recalling what was said earlier, the self, according to Sullivan, is only constituted by and through relations with another (a mothering one). This development begins at the moment of birth, follows "a" history (whatever that might be) and forces within one "an organization of educative experience with the aim of reducing anxiety." Personalities arise against the backdrop of the self-system. Depending on one's developmental history, different personalities may or may not come to fruition.

This distinction is important because it has implications for understanding what kind of knowledge the ITP psychiatrist requires in order to accomplish the goals of this kind of therapy.[40] First, the core of the self, the self-system, is impervious to therapeutic change. What alone can be affected within therapy is the patient's personality. For this reason, it is necessary that the psychiatrist have a good knowledge of the main "patterns" along which most persons in society develop. The

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[39] Sullivan, *Interpersonal Theory,* 104, 110: also, the definition of pattern is "the envelope of relatively insignificant particular differences."

[40] I urge the reader to bear with me through this painstakingly long exposition of Sullivan's theory. However, this paragraph in particular will be of fundamental importance in Section 4. In that section, I will argue against the idea that the *only* goal of ITP is for the client to achieve insight into their patterns of development. Achieving insight might be a goal of this kind of therapy; but if so, it is always of secondary importance. The main goal of ITP is for the client to change maladaptive patterns in living.

bulk of Sullivan's theory is devoted to sketching out this comprehensive taxonomy, including descriptions of the phases of childhood, the juvenile era, preadolescence, early adolescence, etc.[41] General knowledge of an individual's actions during these phases, coupled with the knowledge of how the self-system forms, indicates a general knowledge of the *kinds* of personalities that exist in society.

As stated previously, the self's attempt to strive for an equilibrium between security and anxiety is nothing more than growing in "knowledge in recall and foresight." It is important to recognize that Sullivan believes that individuals learn by doing what is "useful;" that is, by engaging in those behaviors which bring about security and avoiding those actions which cause anxiety. He says:

> When talking about the terms "useful" and "useless" I mean them in the sense of facilitating some activity which is vital in the business of satisfying needs or avoiding anxiety.[42]

On this point, Sullivan's theory is decidedly Humean in feel. Useful behavior, for Hume, is nothing more than engaging in those actions which promote agreeable experiences in the self or others. But, in addition, and a parallel that has yet to be mentioned, is that in *The Treatise of Human Nature* Hume illustrates the link between character (personality, as Sullivan calls it) and actions. He says:

> There is a general course of nature in human actions, as well as in the operations of the sun and the climate. There are also characters peculiar to different nations and

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[41] Sullivan, *Interpersonal*, see table of contents.

[42] Ibid., 119.

> particular persons, as well as common to mankind. The knowledge of these characters is founded on the observation of an uniformity in the actions, that flow from them; and this uniformity forms the very essence of necessity.[43]

The more one observes the regularity and patterns of human behavior, the better inferences one can make regarding individual character. And since there is "a general course of nature in human actions," it would follow that there is a regularity of kinds of character.

Yet, despite Hume's insistence that actions are patterned, he is aware that human beings engage in seemingly capricious or anomalous behaviors. Hume's remarks on this issue are of importance to ITP because it is the psychiatrist who must *know* what is regular and patterned about human nature in order to decipher and treat clients that act in anomalous ways. Consider the following passages from Hume's *Treatise* in which he addresses two possibilities for interpreting seemingly random actions:

> When any phenomena are constantly and invariably conjoin'd together, they acquire such a connexion in the imagination, that it passes from one to the other, without any doubt or hesitation. But below this there are many inferior degrees of evidence and probability, nor does *one* single contrariety of experiment entirely destroy all our reasoning. The mind ballances the contrary experiments and deducting the inferior from the superior, proceeds with that degree of assurance or evidence, which remains. Even when these contrary experiments are entirely equal, we remove not the notion of causes and necessity; but supposing that the usual contrariety proceeds from the operation of contrary and conceal'd causes, we conclude,

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[43] Hume, *Treatise,* II, iii, 402-3.

> that the chance or indifference lies o*nly in our judgement on account of our imperfect knowledge, not in the things themselves,* which are in every case equally necessary, tho to appearance not equally constant or certain.[44]
>
> 'Tis commonly allowed that mad-men have no liberty. But were we to judge by their actions, they have less regularity and constancy than the actions of wise-men, and consequently are farther remov'd from necessity. Our way of thinking in this particular is, therefore, *absolutely inconsistent*; but is a natural consequence of those *confus'd and undefin'd terms*, which we so commonly make use of in our reasonings, especially on the present subject.[45]

These two possible responses to anomalous actions conveniently afford us a subsequent structure for this chapter. I believe that these conclusions are helpful in clarifying some of the most important and interesting aspects of ITP. First, Hume acknowledges that if human behavior appears to be random, the explanation for this rests with the *observer's* "imperfect knowledge," of the agent (and possibly, his culture, station in life, etc.) but not with the agent himself. Since psychiatrist's know patterns of behavior (and confront persons who behave in capricious ways), ITP must offer an explanation regarding the degree to which practitioners have *or should have* an adequate knowledge of character-types (replete with knowledge of the culture in which a person grew up, now works, etc.)[46] Interestingly, in spite of Sullivan's comprehensive exposition of the patterns of human development, he, like Hume, has

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[44] Ibid., 403-4.

[45] Ibid.

[46] See Part 4 of this chapter for a thorough investigation of this topic.

the following comment to make on this point:

> In our civilization, *no* (emphasis mine) parental group actually reflects the essence of the social organization for which the young are being trained in living; and after childhood, when the family influence in acculturation and socialization begins to be attenuated and augmented by other influence, the discrete excerpts of the culture which each family has produced as its children come into collision with other discrete excerpts of the culture -- all of them more or less belonging to the same cultural system, but having *very different accents and importances mixed up in them* (emphasis mine).[47]

The extent to which ITP psychiatrists adequately understand these "very different accents and importances" of various "cultures" of which his client is a member determines the extent to which treatment and the goals of ITP are successful or not.

But the second conclusion to be drawn from Hume's passage is that an observer's understanding of the actions of mentally disturbed individuals is "absolutely inconsistent," because it rests upon "confus'd ideas and undefin'd" terms. It is to this issue, namely, how --- and if--- ITP psychiatrist's understand mental illness that we will now turn our attention.

4) Sullivan's conceptions of mental illness

I will begin this section with an account of what characterizes the normal, "mentally healthy" or "mature" adult according to Sullivan. According to Sullivan, one can only understand this concept by studying what is empirically observable. For,

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[47] Ibid., 169.

if experience is the origin of and justification for the self-system, and the self-system accounts for the formation of personality that ultimately "determines" behavior, then experience is necessarily the place by which to begin an account of what constitutes both "mental health" and "mental illness." In this section, I will argue that Sullivan's conceptions of "mental illness" are not reducible to fixed categories; but rather, "mental illness" is best understood broadly -- in terms of a continuum and as manifested in various kinds of behavior. This claim has an important implication, namely that *all* persons may, at various times in their lives, suffer from "disorders in living" or "mental illness." Because of this, and unlike Hume, Sullivan does not think that one's understanding of mental illness rests upon "confus'd ideas and undefin'd terms." Rather, one understands persons' behavior to the degree that they conform to how the majority of persons in society behave. Yet, Sullivan's conceptions of mental illness raise the interesting and important question as to whether or not it is possible for the psychiatrist to possess truly adequate knowledge of manifest "disorders in living."

Establishing the above claims will highlight interesting aspects of ITP; namely, Sullivan's extraordinarily optimistic view of the persons' ability and natural striving toward mental health. Ironically, Sullivan's optimism about individuals does not translate to societies at large. Rather, he is wary of the health of societies. It is as this point where the psychiatrist may be said to have a responsibility to play the role of the social critic and shift his focus from the individual to the state of societies in

general.[48]

For Sullivan, the end of the juvenile phase signifies the beginnings of maturity. At this point, sufficient socialization has occurred in the development of the self that something akin to a relatively stable personality is established. While it is difficult to identify exactly when a person reaches full maturity, evidence of this threshhold is observed when:

> One is oriented in living to the extent to which one has formulated, or can easily be led to formulate (or has insight into), data of the following types: the integrating tendencies (needs) which customarily characterize one's interpersonal relations; the circumstances appropriate to their satisfaction and relatively anxiety-free discharge; and the more or less remote goals for the approximation of which one will forego intercurrent opportunities for satisfaction or the enhancement of one's prestige. The degree to which one is adequately oriented in living is, I believe, a very much better way of indicating what we often have in mind when we speak about how "well-integrated" a person is, or what his "character" is in the sense of good, bad or indifferent.[49]

I believe that the basic idea Sullivan wants to establish is that a "mature" individual is a "directional" being -- one who has a sense of his basic needs, a knowledge of what situations have fulfilled these in the past and an ability to bring this knowledge to bear on future actions. All of this establishes the self as "well-integrated." Irrespective of

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[48] For an extraordinary example of how the IT psychiatrist might be useful to the work of cultural anthropologists, see Sapir, *Selected Writings,* 575.

[49] Ibid, 243-4.

the various personalities that individuals possess in the world, I think these are the basic features that one must display in order to be deemed "mature."[50]

But what is curious is that Sullivan seems to acknowledge how a psychiatrist's investigations of "mature" persons are severely restricted. Consider the following claim:

> ... the actual fact is that an understanding of maturity eludes us as psychiatrists who are students of interpersonal relations, for the people who manifest the most maturity are least accessible for study; and the progress of our patients toward maturity invariably removes them from our observation before they have reached it. Thus, a psychiatrist, *as a psychiatrist*, doesn't have much actual data. But one can guess a few things. I would guess that each of the outstanding achievements of the developmental eras that I have discussed will be outstandingly manifest in the mature personality. The last of these great developments is the need for intimacy....(emphasis added, mine)[51]

The italicized qualification, *as a psychiatrist,* speaks volumes; for Sullivan is implying that a psychiatrist may have *personal* experiences with mature adults but not clinical

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[50] It is important to note that the concept of "maturity" is independent of normative notions such as "goodness" or "badness." In other words, given the definition of maturity, it is logically possible for a person to be a "directional being" and yet, have an evil character. But, Sullivan seems to think that this could only happen in one of two ways: a) as noted in previous sections, the mother may have shown the infant affection in "malevolent ways." See Sullivan, *Interpersonal,* 214-215. This would produce a damaged self-system. But such individuals would find their way into therapy, for their actions would not be socially approved. b) Entire cultures, (i.e. Nazi Germany) may have evil social rules, and hence, a well-integrated person, in Sullivan's view, might do evil deeds *if they are justified by the society.* In this respect, one can see how important it will be for the psychiatrist at times to assume the role of the social critic.

[51] Ibid., 310.

experience. In their personal life, most everyone has encounters with mature adults. However the "cultures"[52] in which individuals associate are limited; and also, when encountering mature adults in the sphere of private life, they tend not to be viewed as "objects of study." In addition, Sullivan intimates that while "educated guesses" may be useful for the psychiatrist to have a sense of what constitutes maturity in general, as this concept actually functions in the very real therapeutic encounter, he might not have adequate knowledge of how his clients evidence their maturity in their particular "cultures."

At this point, those who are familiar with Sullivan's work might object and claim that I have unfairly depicted his account of mental illness by basing it solely on empirical observation of human behavior. Some might say that Sullivan's training as a medical doctor and in psychoanalysis mitigates any concern that a psychiatrist might possess *inadequate* knowledge of human behavior. After all, what is important is the knowledge of mental illness itself as a *medical diagnosis.* Certainly, one must not overlook how Freudian thought and medical expertise buttress ITP.

Admittedly, there is a clear sense in which Sullivan seemingly incorporates

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[52] What I mean by this is only that in our personal lives, our involvement in and knowledge of "cultures" is limited. For example, a person may be an American and hence may be viewed as part of American society; but if they have lived in the Midwest their entire life, they may not be familiar with "mature individuals" from the South, the East Coast, etc. Sullivan is quite right in eluding to the fact that the psychiatrist, as a psychiatrist and as a person, has a limited knowledge of all of the manifest "cultures"/manifestations of maturity that individuals may display.

Freudian[53] categories of mental illness. In addition, there is evidence that Sullivan even attempted to expand upon the classic, objective understanding of mental illness for he introduces his own array of terminology, ranging from mental deficiency, mental disorders, mental deviancy, etc. More than just an "immature character" or a disorder in living, Sullivan seems to want to construe mental illness in classical and medical terminology.[54]

To such a counter-argument, I would suggest that if one pays very close attention to Sullivan's terminology, one will see a decided move toward "objective" descriptions of mental illness and towards describing mental illness solely in empirical, socially observable terms. As stated at the outset of this section, there is an abundance of terminology: in part, this is due to the various stages in which his texts were written and in part I think it is because Sullivan did not want to disown the Freudian legacy nor deny the scientificity and specialness of the medical establishment.

We might begin exploring my claim by examining his account of "mental illness" as offered in *Conceptions of Modern Psychiatry*. An entire section is devoted to what Sullivan calls, "developmental syndromes." In this chapter, ten syndromes are defined and classified into two general types. Sullivan subdivides these into two

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[53] Also, Kraeplin's objective-descriptive formulations of diagnoses are important in Sullivan's theory.

[54] See Harry Stack Sullivan, *Personal Psychopathology*, with an introduction by Helen Swick Perry, (New York: W.W. Norton & Company, 1972), Ch. 10, 308-326; See also, Sullivan, *Conceptions of Modern Psychiatry*.

groups. The first group of syndromes is described below:

> ... these first five of our syndromes are of early origin in the development of personality. They all come from the time of predominantly autistic verbal behavior. They are deviations of growth that are not chiefly a result of verbal communication between parent and child, teacher and pupil. They occur before the mediate acculturation of the juvenile era...[55]

The second category of syndromes, by contrast, occur "after this spread of acculturation takes on a greater complexity..."[56] The point to note from his list of syndromes is that the first five bear a remarkable resemblance to those traditionally construed along psychoanalytic lines. With respect to two of these syndromes, namely the psychopathic personality disorder and the self-absorbed person, Sullivan even acknowledges the indebtedness of this classification to Kraeplin and Freud's psychoanalysis, respectively.[57] Sullivan calls these first five syndromes, "diagnoses of personality" in contradistinction to the second five, empirically described, "disorders of personality."

In his later book, *The Psychiatric Interview*, Sullivan abandons talk of "mental illness" in terms of syndromes. The new classifications that he introduces, namely mental deviancy, mental deficiency and mental disorder, seem to accomplish the same goal. When discussing the more extreme "mental disorders," Sullivan says the following:

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[55] Sullivan, *Conceptions,* 82-3.

[56] Ibid., 83.

[57] Ibid., 78 (fn).

> I come finally to a group of mental disorders which are probably of most intense interest to the psychiatrist who is concerned with the theory and practice of psychotherapy. The older nosology in this field is undergoing *dissolution*, and one may hope that something much better will arise out of the *disappearance* of ancient errors. I think, however, that the following rubrics still represent important distinctions: 1) those who suffer anxiety attacks; 2) the hysterical, 3) the obsessional, etc. (emphasis added, mine)[58]

Through these examples, I hope to have demonstrated that Sullivan's appeal to objective, medical classifications for his descriptions of mental illness in no way serves as a "corrective" to the psychiatrist's imperfect knowledge of "the mature adult." While it is true that Sullivan inherited a rich classificatory history and probably did not want to undermine the authority of psychiatry as a "science," this in no way destroys the idea that his real method for understanding mental illness rests with empirical observation. This shows his true understanding of psychiatry as a social science. So much is this the case, that when describing mental unhealth, Sullivan says:

> It is, I believe, perfectly correct to say with Bridgman... "I act in two modes... my public mode and in the private mode (in which) I feel my inviolable isolation from my fellows..." Psychiatry studies, as I see it, activity in the public mode and also that part of activity in the private mode which is not in any sense inviolably isolated. Let me say that insofar as you are interested in your unique individuality, in contradistinction to the interpersonal activities which you or someone else can observe, to that extent

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[58] Harry Stack Sullivan, *The Psychiatric Interview,* ed. by Helen Swick Perry and Mary Ladd Gawel. (New York: W.W. Norton & Co., 1954), 190.

> you are interested in the really private mode in which you live -- in which I have no interest whatsoever. The fact is that for any scientific inquiry, in the sense that psychiatry should be, we cannot be concerned with that which is inviolably private.[59]

Here it is clear that only what is empirically observable -- and not what is repressed, suppressed, sublimated, in the unconscious, etc. -- is of interest to the ITP psychiatrist.

Leaving the above account aside, I want to turn my attention to a more substantive account of Sullivan's notions of mental health. Because Sullivan largely understands mental illness in terms of mental health, the optimism that he has regarding the individual drive toward "health" is apparent in his very approach. Yet, in spite of his optimism, Sullivan remains rather skeptical regarding the nature of societies in general. Let us begin with a consideration of the manifold definitions that Sullivan uses to characterize his understanding of mental health:

> Mental health is interpersonal adjustive success.[60]

> ... still the experience of the school may head the self-dynamism in another direction which will make for much greater opportunity for contented living, for mental health.[61]

> Healthy development of personality is inversely proportionate to the amount, to the number of tendencies which have come to exist in dissociation. Put in another way, if there is nothing dissociated, then whether one be a genius or an imbecile, it is quite certain that he will be mentally healthy.

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[59] Sullivan, *Interpersonal,* 19.

[60] Sullivan, *Conceptions,* 97.

[61] Ibid., 40.

> If on the other hand, a person be very talented but be required by his experience, by the significant people who bear on him at various stages in his development, to dissociate from his awareness a considerable number of powerful and durable motivational systems, then that person will be markedly disposed to mental disorder. He will be maladjusted in some of the situations through which his life must develop, and that maladjustment will come about quite certainly, the partition being between those activities of which he is aware versus those which he does with no awareness. [62]
>
> Otherwise, I shall have little or no valid basis for observing the interpersonal processes and formulating an impression of the complexities in them which constitute his maladjustment or mental disorder.[63]
>
> There is nothing unique about any mental disorder except its pattern and perhaps the emphasis laid on various of its manifestations. Thus, we all show everything that any mental patient shows, except for the pattern, accents and so on... [64]
>
> ...patterns of mental disorder and related personality types (involve) recurrent eccentricities in interpersonal relations...[65]

I do not wish to make this an unduly complex account. I believe that in light of the various definitions we find above, the best way to conceive of "mental illness" according to Sullivan is in terms of a failure of mental health. Clearly, as in the case with his "diagnoses of personality" -- because they occur earlier in life -- some failures in mental health may be severe while others, such as the "disorders of personality,"

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[62] Ibid., 47

[63] Ibid., 93.

[64] Sullivan, *Psychiatric Interview*, 173.

[65] Ibid., 185.

may be milder in form. The point is, though, that for Sullivan there are gradations of "mental health."

Why did Sullivan conceive of mental illness in this way? Is there a justification in his theory for viewing mental illness in terms of mental health? I believe this is due to his most famous and foundational assumption, commonly called the One Genus Postulate. He says:

> We shall assume that everyone is simply much more human than otherwise, and that anomalous interpersonal situations, insofar as they do not arise from difference in language or custom, are a function of differences in relative maturity of the persons concerned. In other words, the differences between any two instances of human personality -- from the lowest grade imbecile to the highest grade genius -- are much less striking than the differences between the least-gifted human being and a member of the nearest other biological genus.[66]

If psychiatrists keep their focus on what is common to all human beings, rather than on what makes some different from others, mental health and mental unhealth will be seen as nothing more than variations on one theme: humanity.

This being so, one might wonder, "In Sullivan's opinion, who are the persons who should seek psychiatric help?" Clearly, occasional, isolated instances of one acting *against* the norm would not warrant treatment by a psychiatrist.[67] However,

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[66] Sullivan, *Interpersonal*, 32-33.

[67] This point is, again, very similar to a claim that Hume's makes in the Treatise, III, i, 403. When judging moral actions, Hume tells us not to be concerned with the occasional, random action. He says: "The mind ballances the contrary experiments, and deducing the inferior from the superior, proceeds with that degree of assurance or evidence which remains."

recurrent eccentricities in behavior *might* justify psychotherapeutic treatment. In the end, though, this could conceivably happen to anyone, at any time. As Sullivan says:

> The interviewer has to remember that there is enough in the culture to justify his client having some trouble in living... Every one of us has some trouble in living -- it is ordained by our social order itself that none of us can find and maintain a way of life with perfect contentment, proper self-respect, and so on. ... In the psychiatric interview, the patient believes that he is going to learn something useful about the way he lives.[68]

What Sullivan is really attacking in this paragraph is the notion that culture which is responsible in large measure for what determines successful interpersonal relations has not developed (and probably never will) to the point where everyone could possess perfect mental health. One must recall what was noted earlier, that culture is inherently *irrational.* As such, culture itself mitigates the possibility that persons could ever achieve perfect mental health when described as perfect contentment, perfect self-esteem etc. This leads to a final remark.

Perhaps the definitions themselves patently suggest this, but one must always bear in mind that for Sullivan, whether one is talking about mental health/illness or the like, the diagnosis is made against the backdrop of culture. If cultures are changeable (and they are for Sullivan), then so too are these categories of "mental health" or the "patterns of interpersonal adjustive success." Because of this, the burden that societies bear for establishing "correct patterns of acculturation" is great. For this

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[68] Sullivan, *Psychiatric Interview,* 17.

reason, Sullivan says:

> Psychoneuroses and psychoses result when a society is "twisted" from the purely average in the statistical sense.[69]

In the end, the continuum of mental health is variable against the backdrop of culture. This strongly demonstrates that persons are, to a large extent, not responsible for the failures in mental health. It also suggests that the role of the psychiatrist *should* be more far-reaching than aiding "particular" patients. In short, the psychiatrist may be seen to have the role of the social critic of and for society at large. The point though, after a consideration of all of this, is that patterns of mental health/illness are subject to change, in both time and place.

5) The role of the psychiatrist: the therapeutic encounter

Having explained Sullivan's theory of the self and the nature of mental illness, we are now in a position to see how these concepts are used in the therapeutic encounter and by means of the psychiatrist. Again, although Sullivan's theory is decidedly Humean in its normative agenda, I believe it is precisely when discussing the peculiar role that the psychiatrist plays, that his account leaves much to be desired -- not simply at a theoretical level, but most importantly as it affects the clients who are treated in ITP.

We've seen in the previous section, that (any) person who exhibits a failure in mental health and/or who is experiencing a difficulty in their interpersonal relations is

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[69] Ibid., 6.

a possible patient for therapy. Upon entering into therapy, from an interpersonal point of view, Sullivan would claim that what is established is a "field." Much has been written about the concept of "field theory," for it is not at all easily understandable. The concept itself originated in disciplines other than ITP.[70] Sullivan, apparently, uprooted this concept and found it useful for ITP. He says:

> The field of psychiatry is the study of interpersonal relations and this is a perfectly valid area for the application of the *scientific method.* The psychiatrist's principal instrument of observations is his *self* -- his personality, *him as a person.* The processes and the changes in processes that make up the data which can be subjected to scientific study occur, not in the subject person nor in the observer, but in the situation which is created between the observer and his subject (emphasis added, mine).[71]

In brief, field theory shows that the only *relevant* data in the therapeutic encounter is the interpersonal situation that exists *between* the psychiatrist and the client; or in other words, the "processes" that transpire between two persons. For Sullivan, it is virtually by definition of the nature of the psychiatric interview which demands this approach and thereby denies psychoanalysis' ideal of a therapist as studying the client in a neutral and impartial manner.[72] Sullivan says:

> An interview is a situation of primarily vocal communication

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[70] For an excellent discussion of the history and the confusion surrounding the concept of field theory, see Mullahy and Melinek, *Interpersonal Psychiatry,* 197-199. As this concept operates particularly in Sullivan's ITP, see Mullahy, *Contributions,* especially the chapter by Gardner and McCarthy entitled: "Sullivan and Field Theory."

[71] Ibid., 3 and *Conceptions of Modern Psychiatry,* 5.

[72] See Mullahy, *Contributions,* 162.

> in a two-group, more or less voluntarily integrated, on a progressively unfolding expert-client basis for the purpose of elucidating characteristic patterns of living of the subject person...[73]

Given this cursory overview of "field theory," I suggest that what should concern us is the question: if Sullivan wishes to characterize the therapeutic encounter as a "field of study"[74] that consists of the "processes" that transpire between two persons, how does the therapeutic encounter actually look in practice? Exploring this question will lead us to an investigation of the respective roles of the client and the IT therapist and the nature of *what* occurs between these "two persons."

One must remember that the field itself must be empirically observable. As such, it is constituted by "syntaxic experience" (signs, symbols, language). In *Conceptions of Modern Psychiatry*, Sullivan claims that we might picture the field as follows:

> The situation is not any old thing, it is you and someone else integrated in a particular fashion which can be converted in the alembic of speech into a statement that 'A is striving toward so and so from B.' As soon as I say this, you realize that B is a very highly significant element in the situation... The situation is... the valid object of study, or rather, that which we can observe; namely the action which indicates the situation and the character of its integration.[75]

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[73] Ibid., 4.

[74] In *Conceptions of Modern Psychiatry,* Sullivan calls field theory, "the proper psychiatric methodology," 5.

[75] Ibid., 5.

The above paragraph gives us better imagery of what the therapeutic situation might look like: two persons striving towards an "integration" by their use of shared signs and symbols. However, given this description that "action" between two participants constitutes the data to be studied, one might very well wonder if the ITP psychiatrist is somehow always studying himself in this process. And if so, how? Or conversely, one might question if the client's communications affect the practice -- the person -- of the psychiatrist?

The resounding answer to these questions would *appear* to be yes; although, as we will see, in numerous passages Sullivan *appears* to say no. Let me begin by saying that the use of the term "interpersonal" in this context is rather misleading. Given some passages in his texts, it might have been wiser for Sullivan to admit that *some* personal aspects of the psychiatrist enter into the therapeutic encounter. Admittedly, that claim sounds quite strange. However, consider how Sullivan defines the *content* of the interpersonal situation:

> The setting up of the psychiatric field as a study of interpersonal relations is certainly necessary if psychiatry is to be scientific; furthermore, by this simple expedient of so defining psychiatry, we weed out from 'serious' psychiatric problems a great number of 'pseudo-problems' -- which, since they are pseudo-problems, are not susceptible of solution, attempts at their solution being, in fact, only ways of passing a lifetime pleasantly. Let me repeat that psychiatry as a science cannot be concerned with what is immutably private; it must be concerned only with the human living which is in, or can be converted

into, the public mode.[76]

On the one hand, Sullivan is boldly making a normative claim about what aspects of the person he is and is not interested in possessing knowledge of within the confines of therapy. Moreover, Sullivan is also making claims with respect to what legitimately counts as a psychiatric problem (what is definable and/or treatable) and what is not. In general, one should note that what holds true for the client is also implied for the psychiatrist. The psychiatrist, as well, *should* not allow his private mode of being to enter into therapy.

Consistent with the above view, in *The Psychiatric Interview*, Sullivan is most emphatic in claiming that however "interpersonal" the therapeutic encounter may be, the psychiatrist does not act as a "person," so to speak. He says:

> From the beginning to the end, to the best of his ability, the psychiatrist tries to avoid being involved as a person -- even as a dear and wonderful person -- and keeps to the business of being an *expert.* (emphasis added, mine)[77]

> There is little chance that the interviewee will interpret correctly for the interviewer is not engaged in being anything like a well-rounded person whose durable characteristics would be pertinent to the interview. He is engaged in being an expert at determining what the durable characteristics of the interview are.[78]

Despite the reactionary move of ITP against the neutrality of Freud's psychoanalysis,

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[76] Sullivan, *Interpersonal,* 19.

[77] Sullivan, *Psychiatric Interview,* 34.

[78] Ibid., 97.

Sullivan is not advocating that therapists be empathic. Quite often, in order to describe the role of the therapist, Sullivan uses the seemingly oxymoronic phrase, "participant observer." Clearly, though, the psychiatrist does not participate as a person; but rather, only as an expert. This causes one to wonder, where in this interpersonal field does the psychiatrist's expertise consist? Sullivan explains...

> The psychiatrist is supposed to be at least *somewhat familiar* with practically everything that people do one with another and *to know more* than his client does about the interpersonal relations in *any* field of interest that may be discussed. The psychiatrist catches on to more; he is more informed about what goes on in his relations with others than are even really talented, but not expertly trained people. ...since the psychiatrist is an expert in interpersonal relations, it is not at all strange that the patient comes to the physician expecting him to handle things so that the patient's purposes will be served; namely, that his assets and liabilities in living will be correctly appraised, and that his difficulties will be tracked down to meaningful and remediable elements in his past.[79]

As has been argued in the previous section, *within ITP (for the establishing of the diagnosis),* a psychiatrist's expertise is not to be equated with medical expertise. It had there sufficiently been established that it was empirical observation with a view toward "culture" that truly allowed for successful diagnosis. Let us take it as a given that most rational persons, including psychiatrists, know a great deal about the particular "culture(s)" in which they live. Let us use a thought experiment to see how an ITP might treat a client whose "culture" varies considerably from his/her own.

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[79] Ibid., 27-8.

Consider the following simple example:

> 32 yr. old woman of Haitian descent. Moved to Florida at the age of twelve. Recently moved to Washington D.C. to work at a Catholic High-School teaching history. Married to an American man. Consulting an ITP for despair in marriage.

Imagining if this woman were to consult Sullivan himself for treatment, with the exception of being part of the American culture and now only part of "east coast society," I wish to suggest that Sullivan would have little *understanding* of the other very important cultures of which she is a part, for example, the immigrant Haitian culture of which she is a member. Now some might object and say that Sullivan could have *read* about this other culture. Two easy responses are available on this point: 1) This may be true; but even in this respect, Sullivan has no justification to claim that the psychiatrist *knows more than his client* about the interpersonal relations among Haitians and/or immigrant Haitians interacting with east coast society. 2) Invariably, clients in all of their particularity will show up who are part of cultures of which the psychiatrist will have *no knowledge whatsoever.* In short, psychiatrists can not be expected to know *something* about all interpersonal patterns unless they become cultural anthropologists (and even they would not purport to know *something* about all cultures). But this actually leads to the most important point.

Cultural anthropologists purport to study the patterns of society. As has been said, psychiatrists treat individuals against the backdrop of society/culture. Because they treat the individual, nuances, individual meanings, idiosyncrasies *of the individual* are significant in a way in which they are *not significant* to a cultural anthropologist.

For example, one might imagine if the Haitian woman practiced voodoo. This may be significant in a way that it is *not* to a cultural anthropologist; and yet, it is precisely this fact which is of importance in individual psychiatric treatment. I would venture to say that an up-state New York psychiatrist would indeed know very little, perhaps nothing, about this practice. What I am trying to establish here is that a *psychiatrist's* knowledge of general patterns of behavior may be relatively unimportant in therapy whereas knowledge of the details of an individual's life may be of *essential* importance.[80]

As a counterexample, someone might wish to argue that what is important for the ITP psychiatrist to know is the important phases of the *client's developmental history*. Indeed, Sullivan himself says this at the end of the above quote. Presumably, if clients gained insight into the past as it affects their present, clients would learn something useful for future actions.

In response to this objection, I would say that one must remember that the self-system of any individual is impervious to therapeutic change (see Section 1). It is only the personality (more or less developed at the end of the juvenile era) which might admit of therapeutic change. In the best circumstances, a client's personality will change; however, the psychiatrist knows this to be the case by empirically

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[80] Sullivan, *Psychiatric Interview,* 82. At times, Sullivan acknowledges the importance of a psychiatrist's knowledge of the details of the person, but only to say that knowledge of the details may indicate a pattern. Sullivan fails to acknowledge how details of a person's life in and of themselves may be important and also while the details of a persons life may admit of a pattern, psychiatrist's may have little or altogether lack knowledge of some patterns.

observing a client's behavior. In other words, claims that one's personality has "changed" are known only by *inference.* So too, a psychiatrist's understanding of earlier phases of development rests upon "inference." The upshot that this has for our present discussion is that the less one is acquainted with the cultures of which another individual is a part, the less *reliable* will the psychiatrist's inferences be. One can only imagine the reliability of the inferences Sullivan himself might make about the developmental history of the Haitian woman. This point directly relates to the next.

Given the very different cultures to which the Haitian woman presently belongs (and in the past belonged), the psychiatrist would indeed have very little fellow-feeling, or as Hume would say, feelings of *sympathy* toward her. For Hume, the degree to which a person "sees their like" is the degree to which we have fellow-feeling. He says:

> Now, 'tis obvious, that nature has preserv'd a great resemblance among all human creatures, and that we never remark any passion or principle in others, of which, in some degree or other, we may not *find a parallel in ourselves....* (emphasis added). Accordingly we find, that where, beside the general resemblance of our natures, there is *any peculiar similarity* (emphasis added) in our manners, or character, or country, or language, it facilitates the sympathy. The stronger the relation is betwixt ourselves and any object, the more easily does the imagination make the transition, and convey the related idea the vivacity of conception, with which we *always form the idea of our own person* (emphasis added).[81]

Hume's remark invites two very important challenges to Sullivan's conception of the role of the ITP psychiatrist. For, at the end of the quote, Hume claims that

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[81] Hume, Treatise, II, xi, 318.

one's feelings of sympathy always occur with respect to the idea that one has of *their own person.* As we have shown, Sullivan, oddly claims that the *person of* the ITP psychiatrist -- even though dear and wonderful -- should not enter into the therapeutic endeavor. Yet, as we will soon see, there are enough passages in which Sullivan contradicts himself on this point. But secondly, one might counter and claim that "fellow-feeling"/sympathy, as Hume calls it, although characteristic of human relations, *does not* characterize the therapeutic encounter in ITP. As I will argue, Sullivan argues that the main assumption of any interpersonal field is characterized by "anxiety in search of security." In other words, Sullivan is in complete agreement with Hume and claims it is security that needs to be established *in order to generate the cure/goal of ITP.* I will address both of these concepts below.

The first issue has to do with the fact that the psychiatrist's personal characteristics impact the therapeutic encounter because ultimately, he makes use of his "personal" knowledge of living as the criteria against which the patient is judged. I make this point, because I do not think that it is arbitrary that numerous passages in *The Psychiatric Interview* read as follows:

> One of the reasons for the psychiatrist's initial hesitancy in revealing by means of a summary how at sea he feels in the interview situation is that the sort of things that he summarizes is determined by his own experience and his own grasp on living.[82]
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> If it turns out that nothing about the patient fits with any of the interviewer's past experience, he will really have a grand and difficult task in being

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[82] Sullivan, *Psychiatric*, 82.

> useful to this patient.[83]
>
> {With reference to a case study} And when I have all this information -- and note that I am proceeding in what has gradually been ingrained in me as a system of values that seems natural to Americans -- I become curious, sometimes to the patient's amazement, as to what sort of person his father was...[84]
>
> {When talking about the initial stages of the interview..}. At least, I try to give the client something of my impression of why he is there.[85]

What I am attempting to drive home by citing these remarks, is that there seems to be a willingness on Sullivan's part to claim that the psychiatrist brings his own -- albeit limited -- knowledge of experience to bear on the therapeutic encounter. More than just knowing or being an expert in the rough taxonomy of the developmental stages of the self, here, it seems as if Sullivan is claiming that the "personal aspects" are *quite necessary* within the confines of therapy. But more importantly, the extent to which persons sympathize with the other is the extent to which therapy *will be useful or will have accomplished its goal.* So important is this to the *success of* ITP that I believe, in a rather lucid and honest moment, Sullivan claims the following:

> An identical distortion of living common to doctor and patient makes this type of inquiry (psychiatric inquiry), at best, difficult. Neither is able to see the troublesome patterns..., both become more firmly deceived about life.[86]

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[83] Ibid., 73.

[84] Ibid., 70.

[85] Ibid., 60-1.

[86] Sullivan, *Interpersonal*, 377.

It is curious to note the choice of words in the above passage, for Sullivan clearly states that a possible outcome of ITP is not merely "failure" of treatment; but more radically, a deeper entrenchment of *deception about life.*

The second reason why personal characteristics are *necessary in* the ITP field is because for Sullivan, the actual service of the therapeutic encounter is to be a preliminary foray into the new patterns of behavior concerning future interpersonal relations. He says:

> ...it may become possible to observe
> better the factors that actually resist any tendency
> to extend the integrations of our subject-persons,
> so that they would include representative of other
> groups relatively alien to them -- a Pilot Test of
> which is the integration with oneself...[87]

If the therapeutic encounter(s) serve as testing situations of better adjusted behaviors on the part of the client, then in some sense, the psychiatrist has to use himself (his own experience of interpersonal patterns) as some kind of criterion of mental health. At the very least, the psychiatrist will be assuming some kind of personality that comes replete with details (based on the *personal* experience of the psychiatrist). Perhaps an example will better illustrate this point: One could imagine a patient who enters therapy who has a problem with his boss. Imagine that this patient works in the computer industry. Now, the psychiatrist's actual knowledge of corporate structure may be limited or it may be vast. The point to note is that in his assumed role as his patient's boss, invariably he has to bring his own knowledge (or lack thereof) to bear

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[87] Sullivan, *Interpersonal,* 377.

in his performance. The extent to which a client experiences success in the confines of therapy, acts as a predictor as to whether or not the success will continue to occur outside of therapy. In this regard, the degree to which the psychiatrist effectively (or not) performs his role directly bears upon the success in living that the client will experience (the restoration of mental health).

Finally, let me suggest that the personal characteristics of the psychiatrist enter into the therapeutic encounter in the most important and necessary way by means of his anxiety -- anxiety, of course, which is in search of security (or, sympathy as Hume would say). There is this sense that anxiety is somehow first and foremost our natural state of being-with-others,[88] and that individuals constantly strive to overcome it by the "establishment" of security. I believe it is fair to say that in this respect the therapeutic encounter imitates the manner in which the self develops. Sullivan often states that the client presents to the psychiatrist precisely with a need to remedy his trouble in living *and* at times, to ameliorate anxiety. Anxiety is said to have the following very important role within the therapeutic encounter:

> Anxiety as that which makes communication possible in the therapeutic encounter: When there is no anxiety, a true interview situation does not exist. [89]

Although anxiety is always underlying any interview situation, anxiety is always in

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[88] At times, it seems as if Sullivan believes that any human encounter provokes anxiety. When characterizing humans stages of development, at one point he states: "Well this is how lovely life was and then I realized there were people... " It appears as if anxiety is a presupposition of any interpersonal encounter.

[89] Sullivan, *Psychiatric Interview,* 102.

search of security. *Some kind of connection* based upon fellow-feeling becomes the goal of ITP therapy.

6) Goals of therapy

Speckled throughout the subsequent sections have been hints as to what constitutes the goals of ITP for the client. We might begin with overtly acknowledging what is *not* a desired goal; namely pleasure. Indeed, insight desired for only its own sake is also not encouraged. Insight may be a mediant, though not an end-goal, of ITP. In other words, since Sullivan's notions of mental "unhealth/illness" are based on a continuum conception, then ITP is honest in claiming that if clients leave with having learned "something" that is conducive to *living* in their respective cultures, then it has been worthwhile.[90]

The emphasis in the above paragraph, I would, argue should be on "living," rather than on one's having "learned" something. Again, Sullivan, like Hume, is an empiricist. One knows that one has succeeded in therapy to the extent to which one's actions better conform to the expectations of his/her relevant cultures. A psychiatrist, indeed, anyone, can only make *inferences* as to whether or not personality or character has been modified. However, the true test of success in this form of therapy is judged by what is observable. As such, Sullivan is quite right to express only hope -- and not certainty -- that the "pilot test" will be of some use to his client's future behavior. To encourage psychiatrists to make ITP as successful as possible for their

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[90] For example see Sullivan, *Psychiatric Interview,* 42.

clients, Sullivan says:

> I suggest that a psychiatrist find out something about a person before he makes or implies expansive promises about what he will do, or what ought to be done, and particularly before he begins to do something which may or may not have any earthly constructive influence on the patient.... The psychiatrist should try to orient himself as to certain basic probabilities according to the developmental scheme of things.[91]

What is important for the reader to recognize is Sullivan's honesty both about what psychiatry can do and what the psychiatrist (and the client) may know about the "cure" that results at the end of treatment. Like Hume who claimed that human knowledge about matters of experience rests upon probability alone; so too, does Sullivan claim that whether or not the client will manifest more useful patterns of living (and hence, achieve a meaningful cure of therapy) is, ultimately, a matter of faith. I call this a "matter of faith" because for Sullivan, what the client has learned in therapy will only be meaningful when one *acts* accordingly. Thus, depending upon how well the client "performs" in the pilot test acts as a kind of predictor about how well they will perform their activities in the real world. The better the performance in therapy, the more assured *both the psychiatrist and client may feel* about the client performing these activities in the real world. In this respect, both will be more assured that ITP therapy was useful -- successful -- for the client.

With respect to the content of these actions; Sullivan in no way explores what these might be; for an individual's behavior must correspond to the culture(s) of which

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[91] Ibid., 77.

he/she is a part. This is an extremely important point to acknowledge because not only does it indicate that Sullivan is an empiricist with respect to moral issues; but also, that he is a relativist of some sort. This stands in marked contrast to what one author has to say about Sullivan's "ethical theory:"

> For Sullivan, the "good" is generally identified with the state of human maturity, already described in the "fully human estate," and characterized as dignity, self-respect, competence and freedom.[92]

Lawson is quite right in saying that dignity, self-respect, etc. are values that appear in adolescence, or what is commonly considered to be the last phase of personality development. Yet, drawing the further normative notion from this by saying that Sullivan's description of maturity functions as some "abstract" rationalistic notion of what all persons should aspire to -- the good, or the good life -- is a faulty interpretation. In particular, with respect to competence and freedom, these are all but absolute or well-theorized notions in ITP. In themselves, they may be pleasant to have; but they are not intrinsically necessary for the establishment of mental health. The same could be said for the concepts of dignity and self-respect. Some might wish to say that a sense of dignity and self-respect are essential to *acting in* useful ways, or are somehow necessary for acting well with others. There is some evidence that Sullivan does seem to think this is the case; but remember, the beauty of ITP both broadly and minimally is that people are ultimately judged by how they live. Dignity and self-respect, then, are only evidenced through actions.

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[92] Lawson, *Teaching of Values,* 63.

In conclusion, it is hoped that the reader will see that there can not be, in principle, any one set of ethical maxims that are suggested to all clients during and as a goal of treatment in ITP. Values that are suggested to the client in the course of treatment will and do vary according to the values that are esteemed within *a client's* given culture(s). As I have attempted to demonstrate, Sullivan himself seemed to be aware, though did not consistently express, that the success of treatment largely depends upon the psychiatrist's familiarity with the client's past and present patterns of behavior.

Nonetheless, there are consistent normative notions that the psychiatrist must adhere to if he purports to practice ITP. These, as I have argued, are strikingly similar to those professed by David Hume. In the end, it could safely be said that what is important to inculcate for the client both within treatment and as the goal of therapy is for him to experience feelings of security and approval from others. Psychiatrists are experts in this field to the extent that they can do the work, in part, of the cultural anthropologist. In this respect then, the ITP psychiatrist is indeed a relativist with respect to values. However, it is also important acknowledge that an ITP psychiatrist may be required to be a social critic when it is deemed that particular cultures do not advocate security.

By way of illustration, biographer Helen Swick Perry says that in his later years, Sullivan suffering from ill health and yet living in the aftermath of Hiroshima, had to make the difficult decision to take care of his own health or advance scholarship in the human sciences towards issues of social responsibility. She writes:

> His own comment on his decision was typical of Sullivan: "It appears that I'm about to make even more of a fool of myself than usual, but, by God, I'm going to try it!" From that moment on, Harry Stack Sullivan paid no more attention to his heart or to his medical advisors.[93]

So great were Sullivan's worries about social cohesion in the wake of Hiroshima that until the day he died he was involved in issues of social activism. He urged other psychiatrists to engage, as he did, in interdisciplinary mental health congresses in order to explore "improper child training."[94] Knowledge thus gained could enlighten the public about ill-founded cultural practices for the sake of encouraging better mental health, and more importantly social progress. In this respect, then, Sullivan was an absolutist; for, as society moved toward seeming chaos, Sullivan fought for greater bonds of sympathy. As the founder of ITP, Sullivan founded a theory which legitimated future psychiatrists to play the role of the social critic, social activist, moral psychologist and cultural anthropologist. To the extent that ITP psychiatrists can play these roles is the extent to which they serve their clients and society at large.

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[93] Helen Swick Perry, *Psychiatrist of America*, 404.

[94] Ibid., 407.

CHAPTER THREE

ANALYSIS OF VIKTOR FRANKL'S LOGOTHERAPY

In *The Will to Meaning*, Viktor Frankl claims that "no psychotherapy is immune to values; there are only psychotherapies which are blind to them."[1] More than any other paradigm of psychotherapy analyzed in this dissertation thus far, Frankl not only seeks to expose but even flaunts the philosophical and normative assumptions that underlie logotherapy. Less than a century since Freud claimed "scientific" status for psychoanalysis Frankl argues, by contrast, that it is the spiritual dimension of the person which lies at the heart of mental wholeness or health.

The task of this chapter is to examine the normative force that a logotherapy's philosophical assumptions acquire in the clinical context as they: a) function in establishing the client's diagnosis, b) define the role of the therapist and the techniques of treatment and most importantly, c) determine the goal(s) of therapy. Identifying these assumptions would seem to be a relatively straightforward task considering how much attention Frankl gives to these concepts in his writing. Chapters abound entitled:

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[1] Viktor E. Frankl. *The Will to Meaning: Foundations and Applications of Logotherapy,* expanded ed. (New York: Penguin Books, 1988), xi.

"Dynamics and Values of Therapy," "The Philosophical Foundations of Logotherapy," etc.[2] Paradoxically, despite Frankl's discussions of these underlying assumptions, very often a true grasp of their meaning remains elusive.[3] For this reason, part of this analysis will consist of a reconsideration of Frankl's justifications for logotherapy, his view of the human person and what he calls, the "objective realm of values."

It is my contention that when one examines the philosophical assumptions of this paradigm on their own terms and for the consequences that they might entail, the internal consistency of logotherapy as a discipline begins to erode. I will demonstrate that the theoretical incoherence of logotherapy has two important implications for its practice:

1) the nature of the expertise of logotherapists is unclear
2) any number of goals could potentially result for the client at the end of treatment.

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[2]Viktor E. Frankl. *Psychotherapy and Existentialism, Selected Papers on Logotherapy* (New York: Washington Square Press, 1967), 4.

[3] I suspect this is the case for two reasons: 1) So as to differentiate logotherapy from other psychological schools of thought, Frankl often appeals to rich philosophical traditions to establish his theory. For example, he claims that logotherapy borrows many of its concepts from existentialism and phenomenology. The richness and breadth of these two traditions and the various persons who have advanced them suggest that terms, such as "being" and "reality" admit of various meanings. For this reason, the philosopher reading Frankl's texts will look for precision regarding the meaning he gives to these terms. 2) Because traditional philosophical assumptions are uprooted from their context and being employed for a different end -- the establishment of logotherapy -- these concepts acquire subtle shifts of meaning. For these two reasons, then, I call them "elusive."

In a variety of senses, I will argue that relativism lurks beneath logotherapy. Rather than having established "*the* meaning of being human therapy" and attempting to remedy clients' ailments by means of its methods, Frankl can only honestly be said to have put forth *an* interpretation of *a* meaning of being human. As this last claim is itself interpreted by individual practitioners of logotherapy, in its very real and human context, any number of possible values may be achieved by the person who seeks this kind of treatment.

Admittedly, the above paragraph reads as a very complex thesis statement. To aid the reader to see the force that my interpretation has and to see it unfold from the variety of perspectives under which logotherapy can be viewed,[4] the main themes of this chapter are outlined below:

1) Historical background and purpose of logotherapy:
   a) Why did this form of therapy arise and for what end(s)?
   b) Is logotherapy merely a "supplement" to psychotherapy?
2) Logotherapy's view of the person
   a) Frankl's dimensional ontology
   b) Preliminary consideration of mental illness
   c) The tragic triad of human existence: pain, death and guilt
3) "Logos" (meaning): The objective realm of experience
4) How do we know the objective realm of experience: the role of intuitive conscience
5) Bridge: What has been accomplished?
6) The therapeutic encounter:
   a) Treatment of the clinical neurotic

[4] What I mean by this last phrase is simply that the clinical encounter involves at least two different points of view - that of the client and the therapist. When one adds temporal considerations to this, i.e. the client's view at the beginning, during and at the end of therapy, one can see how logotherapy could be viewed from a variety of perspectives. Of course, and as I have been suggesting, underlying these perspectives is the theory itself (the philosophical assumptions) that the logotherapist purportedly adopts.

b) Treatment of the existential neurotic
7) Conclusion

1) Historical background and purpose of logotherapy: 1a) Why did this form of therapy arise and for what ends?

In his first chapter of *The Will to Meaning*, Frankl acknowledges the historical indebtedness of logotherapy to other forms of psychotherapy.[5] Accordingly, logotherapy draws from Freud's psychoanalysis and even the philosophical writings of Martin Heidegger, Max Scheler and Martin Buber. Yet, because logotherapy merits its own name and interprets the concept of mental health in a unique manner, Frankl is eager to point out the differences between his version of therapy and those of his predecessors.

In order to situate his version of therapy in the scheme of existing paradigms, Frankl claims that logotherapy can be viewed as a branch of existential or onto-analysis.[6] Like Ludwig Binswanger, Frankl agrees that psychotherapy should be concerned with the human person's "being;" however, unlike Binswanger, Frankl maintains that "being" requires the corollary of "meaning." It is because existential analysts overlooked this second and necessary correlate of human existence that Frankl saw the need to further develop this school of thought by means of logotherapy.

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[5] Ibid., 3-12.

[6] Ibid., 5.

Both theoretically and practically, the addition of the concept of meaning is essential because the self, for Frankl, simply can not be understood without some reference to an "other." As opposed to the philosophy of Sartre and Binswanger's (incomplete) existential analysis, Frankl maintains that the self can neither be what it is nor become what it should be when considered against the background of nothingness. An other/meaning(s) is required for human being-in-the-world.[7]

The theoretical rationale for this view rests, in part, on a more complete conception of the nature of the person. In Frankl's view, previous schools of psychotherapy overlooked the importance of logos precisely because they took for granted the intrinsic spiritual core of the human person. Viewing the human person as a combination of body and psyche forced the unpalatable conclusion that the human person is solely a mechanism and driven by instincts. Although both psychoanalysis and interpersonal forms of therapy have addressed these aspects of the human person, their inadequacy lies in not recognizing that it is the spiritual (logos-seeking) aspect of the human person which "constitutes oneness and wholeness in man."[8] Logotherapy

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[7] As we shall see in subsequent sections, the therapeutic setting itself must imitate this self/other relationship. It is the logotherapist who facilitates the clients' being to come in contact with meaning(s). As Frankl states in *The Will to Meaning,* 11-12: "...if self-understanding is to be reached, it has to be mediated by encounter. In other words, Freud's statement, where id is, ego should be, could be enlarged; Where id is ego should be; but the ego can only become an ego through a Thou."

[8] Viktor E. Frankl. *The Unconscious God: Psychotherapy and Theology* (New York: Simon and Schuster, 1985), 28.

addresses the spiritual dimension of the person and by implication, logotherapists attempt to bring their clients into contact with "meaning."

In this section, I have attempted to summarize one motivation that led to the formation of logotherapy.[9] When viewed in its historical context, it can be seen as an intellectual development of existing psychotherapeutic paradigms. For this reason, Frankl frequently speaks of logotherapy as "supplementary" to traditional psychotherapy.[10] Yet, even a cursory glance at the underlying rationale for logotherapy -- involving as it does a more complete conception of the nature of the person and a discussion of meanings -- makes one wonder if it is more appropriate to say that logotherapy constitutes a "revisionary" or "radically new" form of psychotherapy. Determining whether or not logotherapy is intended to be only a supplement to psychotherapy, or perhaps something more, is extremely important. It will enable one to have a clear sense of what it is that logotherapy intends to do, both theoretically and practically for the client who seeks this kind of treatment. Attempting to answer this question directly leads us to the next question of this chapter.

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[9] It would be an oversight not to acknowledge the personal motivation that led to Frankl's logotherapy. See Frankl, *Doctor and Soul*, x. There, he says that his experience in the concentration camps served as a "testing ground for the main tenet of logotherapy." Much of the theory had been developed prior to his entering the concentration camps; however, the work was taken from him by the S.S. The thought of reconstructing the book served as an orientation toward a meaning which had survival value for him while in the camps.

[10] Ibid., xii, 17, 270.

1b) Is logotherapy merely a supplement to psychotherapy?

An architectural metaphor may be helpful to illustrate the nature and the importance of the above distinction. One might compare "traditional psychotherapy" to a classically constructed building. If, as Frankl often claims, logotherapy is a "supplement and not a substitute for psychotherapy," one might imagine that logotherapy adds necessary structural supports to the already existent building. Even with the supports, the overall appearance of the building remains the same. However, if one construes logotherapy as revisionary, one might imagine in light of the metaphor that it adds new and different supports to the building. If the support system were "radically new," such as an inner steel frame might be for a classically constructed building, it would necessarily follow that the overall appearance of the building would be different. One might imagine that a classically constructed building with an interior frame structure would no longer even bear a resemblance to what it once was; but rather, it might look like a modern-day skyscraper. The same would be true if one were to view logotherapy as providing foundations of a "radically new" kind for psychotherapy. Traditional psychotherapy would no longer look as it does. It would, by necessity "become" something different.

Repeatedly in his writings and as noted before, Frankl maintains that logotherapy is supplementary to psychotherapy and because of this, is not applicable to all traditionally conceived mental illnesses. Logotherapy, properly speaking, only addresses the spiritual core of the human person and does not purport to treat the body and psyche. Because of this, Frankl sometimes speaks as if logotherapy is only

applicable to those who suffer from uniquely spiritual illnesses (i.e. the existential vacuum, collective neurosis). If we are to interpret Frankl literally on this point, a practical problem emerges for the potential client of logotherapy: If the human person, metaphysically speaking, consists of a body, mind and spirit, is it possible that one see a psychiatrist for medical management, a psychotherapist for interpreting one's psyche and a logotherapist for concerns of the spirit/meaning? Are three different "professionals" needed? Viewing logotherapy as a "supplement and not a substitute" for psychotherapy would seem to delimit its appropriate sphere of intervention to only and exclusively matters of the spirit. Practically, this would mean that clients might need treatment from other professionals.

In other passages, Frankl rejects the above consequence.[11] By doing so, it appears as if Frankl intends logotherapy to be more than a mere "supplement" for psychotherapy. For example, some chapters of Frankl's books are devoted to demonstrating how classic (psychoanalytic) mental illness, i.e. obsessional neurosis, anxiety neurosis, sexual frustration can be "cured" by means of logotherapy's techniques.[12] In addition, his characterization of logotherapy as a medical ministry

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[11] Frankl, *Will to Meaning*, 151-2. " I am reminded of the American doctor who once turned up in my clinic and asked me, 'Now, doctor, are you a psychoanalyst?' Whereupon I replied, 'Not exactly a psychoanalyst; let's say a psychotherapist.' He then asked me, 'What school do you stand for?' I answered, 'It is my own theory. It is logotherapy.'"

[12] Frankl, *Doctor and Soul*, 176-209.

highlights the therapeutic effects that logotherapy may have on the body.[13] More than a supplement, logotherapy purports to do the following:

> The applications of logotherapy discussed in this book are also threefold: First of all, logotherapy is applicable as a treatment of noogenic neurosis; second, logotherapy is a treatment of psychogenic neuroses, i.e. neuroses in the conventional sense of the word; and third, logotherapy is a treatment of somatogenic neuroses, or for that matter, somatogenic diseases in general. As we see, all the dimension of a human being are reflected in this sequence of subject matters.[14]

Indeed, as Frankl himself argues in this passage, "all the dimensions" of the human being can be addressed by logotherapy's applications. Far from treating a mere one-third of our total human nature, the above citations show that logotherapy aims to do much more. In my view, these two incompatible accounts of the purpose of logotherapy rest upon Frankl's ambiguous account of the nature of the human person. As noted before, Frankl is eager to point out the philosophical foundations of logotherapy; however, and as we will see in the next section, his discussion of the nature of the person admits of two very different interpretations. In sum, depending on what view of the person the logotherapist ultimately adopts determines if

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[13] Ibid., 281. "Medical ministry belongs in the work of every physician. The surgeon should have recourse to it as much and as often as the neurologist or psychiatrist. It is only that the goal of medical ministry is different and goes deeper than that of the surgeon..... Where actual surgery comes to an end, the work of medical ministry begins. For something must follow after the surgeon has laid aside his scalpel, or where surgical work is ruled out -- as, for example, the inoperable case."

[14] Frankl, *Will to Meaning*, viii.

logotherapy is only a "supplement to psychotherapy" or is, in fact, "revisionary in nature.[15]

2) Logotherapy's view of the human person
2a) Frankl's dimensional ontology

Frankl's account of the self was modified over the years. Yet, unlike Freud, it could be argued that Frankl merely used different language to describe the self and did not substantively change his theory. In other words, Frankl's view of the self remains essentially the same. It is also, as I will argue, a consistently vague theory. For, whether one considers Frankl's earlier or later work, both accounts admit of at least two interpretations of the nature of the person. In what follows, I will describe these two competing conceptions of the self and demonstrate how each implicitly supports different aims of logotherapy as a discipline -- as either supplementary to psychotherapy or as a revisionary form of therapy. Curiously, it will also be shown that Frankl himself seems to favor one conception of the human person as opposed to the other and, therefore, most likely does construe logotherapy as a "revisionary version of psychotherapy." Consequences that this interpretation has for other aspects of his therapy will be noted (i.e. descriptions of mental illness, motivational account, causal account, etc.).

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[15] It goes without saying that if logotherapy theoretically admits of two different interpretations regarding the nature of the person, then which view a logotherapist adopts for practice is a matter of individual choice. In this way, arbitrariness is imbued in the nature of the "expertise" that logotherapists claim to possess. This individual choice might imply different goals for the clients treated by this form of therapy.

Frankl's 1947 text, *The Unconscious God,* is one of his first attempts at characterizing the nature of the human person and the need for logotherapy. Even in this early work, the primacy that Frankl accords to the spiritual dimension of the person is apparent. However, in this book, Frankl's account seems constrained by the language of depth psychology. Like Freud, Frankl employs the notions of the unconscious and conscious. Only unlike Freud, in this account he claims that "the spiritual basis of human existence is ultimately unconscious."[16] Rather than merely being the locus of instincts, the belief that the human person is fundamentally a conscious and responsible agent is rooted at this primordial level of being. Presumably, Frankl expands the notion of the unconscious in this way so as to align logotherapy (in terms of technique) with psychoanalysis. Just as Freud believed that unconscious material needed to be made conscious; so too, Frankl claims that in logotherapy one is consciously made aware of their basic human nature: of being a free, responsible and spiritual being.

In his later work, Frankl abandons talk of the spiritual unconscious which is at the root of the self. I suspect he did this for two, somewhat related reasons: 1) It seems plausible to suggest that Frankl realized the limitations of the language of depth psychology to characterize the nature of the spiritual self. Even in his early work, Frankl seems to struggle with talk of a spiritual unconscious which is essentially free and responsible. This leads him to make obscure claims such as "spiritual phenomenon may be unconscious or conscious."[17] 2) Inspired by the work of Nicolai

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[16] Frankl, *Unconscious God,* 31.

Hartmann and Max Scheler, Frankl realized that the language of "dimensional ontology" better characterized his view of the person.[18] Even with this improvement, however, two competing interpretations can be derived from this account.

In later work, Frankl adopts a concentric circle approach for analyzing human nature. The core of the self is the spiritual center which is the locus of two, irreducible ontological features: consciousness and responsibility.[19] Encircling our spiritual core (and in this order) are the psyche and the body. To speak of the self as having "aspects" -- consisting of strata or layers as Hartmann or Scheler claim, -- does "justice," Frankl says "to the ontological differences of the human person."[20] It is this view of the person which implicitly supports the view that logotherapy is a supplement and not a substitute for psychotherapy.

Nonetheless, despite these ontological differences, Frankl is adamant that the self be viewed as a unity. Indeed, he criticizes Scheler's and Hartmann's account for failing to emphasize the "unity that man is, a unity in spite of multiplicity."[21] Concern for presenting a holistic view of human nature is apparent even in his treatment of the self in *The Unconscious God.* In that text, Frankl critiques Freud's psychic atomism; namely that the human being is conceived of in terms of distinct parts: the id, the ego

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[17] Ibid.

[18] Frankl, *Will to Meaning,* 22.

[19] Frankl does seem to want to justify these assumptions. For an example, see *Doctor and Soul,* fn. 5-6.

[20] Frankl, *Will to Meaning,* 22.

[21] Ibid.

and the super-ego. Frankl's dissatisfaction with Freud's characterization of the self is that it implied that the task of psychoanalysis was to reconstruct the whole person out of mere fragments.[22]

It is hoped that the reader can now see why logotherapy may have two very different aims. Depending if one gives precedence to the three, ontologically different aspects of the self, one may construe logotherapy as a supplement to psychotherapy. While this interpretation is warranted based on his description of the self, Frankl probably realized that too much emphasis on these ontological differences would expose logotherapy to the same kind of criticism to which psychoanalysis falls prey. If, on the other hand, one views the self as an integrated unity -- as Frankl seems to advocate -- then logotherapy is indeed a revisionary form of psychotherapy and even more, a medical ministry. If Frankl's view of the person is "revisionary" in this sense, one can expect that his descriptions of what constitutes mental illness will be different as well.

Giving precedence to the self as a unified whole has some interesting consequences for logotherapy, now viewed as a revisionary form of psychotherapy. Two of these implications are alluded to in the following passage:

> Of necessity the unity of man -- a unity in spite of the multiplicity of body and mind -- cannot be found in the biological or psychological but must be sought in that noological dimension out of which man is projected in the first place.[23]

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[22] Frankl, *Unconscious God,* 21.

[23] Frankl, *Will to Meaning,* 25.

If the unity of the person rests upon the noological (spiritual) core of the self, by necessity the three dimensions of the person are hierarchically arranged. As a result, it will be shown that for Frankl it is the spiritual core of the human person which functions as the foundational and most important aspect of our existence. If this is the case, then one might expect Frankl to provide the reader with a causal account of how it is that the spirit "impacts" the other two dimensions of the self. In sum, some kind of causal story that explains the connections between these three strata is needed. Finally, if it is consciousness and responsibility that capture the essential nature of the human person, one might wonder what importance Frankl might grant to a client's desires in the confines of therapy.

In the next section, we will turn to an examination of Frankl's notions of mental illness. If the above is a correct characterization of the person, then perhaps a preliminary understanding of the nature of mental illness can be reached. Such an investigation may carry with it the possibility that normative assumptions attached to these definitions can be glimpsed.

2b) Preliminary consideration of mental illness

Understanding logotherapy as a revisionary psychotherapy due to its metaphysically enriched description of the person suggests that traditional conceptions of mental illness will be altered.[24] As mentioned in an earlier section of this paper, Frankl's

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[24] By the phrase, "traditional conceptions of mental illness and normalcy," I am simply referring to those schools of thought which characterize mental illness solely in terms of a psychological data, i.e. Freud's psychoanalysis and H.S. Sullivan's interpersonal theory of psychiatry.

logotherapy does purport to treat schizophrenia, obsessional neurosis, anxiety neurosis, etc.[25] However, one must bear in mind that the meaning assigned to these terms is markedly different; that is to say, they are literally "re-viewed" through the lens of logotherapy's understanding of what it means to be a person. In this section, we will engage in a preliminary consideration of how Frankl conceives of mental illness.[26]

Since the biological and psychological aspects of the self are said to constitute human facticity, one might wonder how various psychological states (i.e. feelings of frustration, erratic ideas, racing thoughts) and/or behavior (i.e. compulsive hand-washing, avoidant activities) affect his definitions of mental illness. When seen from the spiritual dimension of the person, as logotherapy asks us to view these data, neither psychological nor behavioral data contribute to these conceptions in any meaningful way.[27] Quite simply, they are said to constitute a human person's "destiny." What remains central to the concept of "normalcy" is that one's spiritual core -- the core of conscience and responsibility -- is unscathed by destiny. Provided that one makes a

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[25] Frankl, *Doctor and Soul,* 176-206.

[26] I call this a "preliminary consideration" of mental illness and normalcy because we are considering these notions on their own terms. One must remember that for Frankl, the self can not be wholly understood in isolation; rather, an "other," is required. We have yet to consider the nature of the corollary of being. As such, this section is only to be considered as a preliminary investigation of mental illness.

[27] See Section 6a of this chapter for a further explanation as to why only the spiritual dimension of the person contributes to a meaningful understanding of mental illness.

[28] Frankl, *Doctor and Soul,* 75.

choice or takes a stand toward these data, a person's essence will not be impacted by such facticity. This theme is expressed in numerous ways in *The Doctor and the Soul*:

> The mind is contingent upon instincts and existence is contingent upon substance. This destiny can be transcended.[28]
>
> Destiny must always be a stimulus to conscious, responsible action.[29]
>
> Biological destiny is the material which must be shaped by the free, human spirit.[30]
>
> Man's psychological fate, meaning by this, those psychic factors which stand in the way of spiritual freedom. The ego can decide, freely; the ego can have control over the instincts.[31]

On this reading, I think one can assume that "mental illness" may still be said to exist, although one may be said to be spiritually normal. Invoking the view of the person as ontologically stratified would allow for this interpretation, though it would seem to entail some extremely undesirable implications.[32] Because of this, I would maintain that Frankl reconstrues traditional conceptions of mental illness by means of

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[29] Ibid., 79.

[30] Ibid., 83.

[31] Ibid., 85.

[32] One could certainly imagine a case where someone believes he should commit suicide. It would appear as if logotherapists would have to concede that this person is spiritually healthy provided they have taken a conscious and responsible 'stand' toward their destiny. Yet, Frankl himself denies this implication. In *The Will to Meaning,* 67, he says: "I am personally glad to take the blame for having been directive along the lines of a life-affirming *Weltanschauung* whenever I have had to treat the suicidal patient."

his integrated understanding of the nature of the person. In large part this is accomplished by a broader understanding of the nature of the symptom. When one understands what constitutes a "symptom" in logotherapy, one will have to concede that logotherapy radically reconstrues the nature of "mental illness."

When discussing the nature of the symptom in *The Doctor and the Soul*, Frankl draws parallels between the expression of the symptom and the human person's three ontological dimensions. He says the following:

> The symptom is never merely a consequence of some somatic factor and the expressions of some psychic factor, but it is also a mode of existence -- and this last element is the crucial one (i.e. somatic factors in the concentration camp included lack of sleep, hunger; psychological expressions included inferiority feelings, depression, etc.) But ultimately, symptoms express a spiritual attitude. For in every case, man retains the freedom and the possibility of deciding for or against the influence of his surroundings.[33]

I believe that the language Frankl uses in the above passage to characterize the symptom supports my view that Frankl does indeed re-construe traditionally conceived notions of mental illness and normalcy. Characterizing the most "crucial" aspect of the symptom as being a "mode of existence" and that "ultimately, it is a spiritual attitude," can not help but forge new understandings. What emerges, though, from this consideration is a paradox: If it is the case that symptoms can be expressed at the spiritual level and manifest themselves at this conscious, free dimension, one wonders how *"in every case,* man retains the freedom and the possibility for or deciding against" anything whatsoever. In other words, the spiritual dimension of the person is

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[33] Frankl, *Doctor and Soul*, 97.

the very aspect of the person which is capable of free, conscious and responsible choices; yet, it is this very dimension of the self which also can fall prey to "symptoms." This paradox could be resolved if Frankl would speak of the spiritual dimension as somehow stratified; yet, this possibility is not addressed. Rather, Frankl seems to want to stress the unity and wholeness of each of the three aspects of being. While this paradox has been shown to exist in other paradigms of psychotherapy, it is my contention that it will pose particularly acute problems in existential versions of psychotherapy.[34]

I believe that a logotherapist has three possible stands to take with respect to this paradox: 1) either the spiritual dimension of the person is completely immutable in the face of mental, even spiritual illness; 2) the spiritual dimension suffers at some level and is immutable at some level;[35] 3) the spiritual dimension of the self suffers completely -- conscience and responsibility are incapacitated. There is evidence that Frankl adopts all three of these positions. [36] Since the above example can be interpreted as illustrating either the first or second position, I will focus on the theoretical evidence for the third possible interpretation of the paradox.

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[34] See Section 6a of this chapter for a further explanation.

[35] Ibid., 195, "Obsessional neurosis is not a psychosis; the sick person's attitude is still relatively free."

[36] From my point of view, Frankl's implicit adoption of all three stands without *clearly justifying them* to the reader and more importantly to the logotherapist necessarily ushers a certain arbitrariness into this discipline. I remind the reader that analysis of the paradox lends support to my thesis: namely, that logotherapy involves "incoherent" metaphysical assumptions and as a result ushers relativism into its practice.

At times, Frankl speaks of uniquely "spiritual illnesses" or "spiritual suffering." There is evidence which suggests that this suffering can be experienced in either one of two ways: either persons are incapable of *actualizing* their freedom and responsibility; or, persons *have a distorted view* of their basic human nature.[37] In the former case, Frankl claims that these cases of spiritual suffering represent the "greatest human accomplishment." For, it is at these points that one most fully *realizes* their essential nature; namely, to be a free and responsible being. In the latter case, Frankl does not call this distortion an ""accomplishment," but neither does he call it "a mental disease; let alone a disease of the spirit."[38] Rather, cognitive distortion of one's basic nature constitutes a "particular philosophical position" or a "particular world-view."[39]

Our preliminary excursion into the nature of mental illness has resulted in revisionary conceptions of its nature. One might even suggest that in logotherapy, the term, mental illness, is somehow obsolete. To summarize what has been accomplished, logotherapy "allows" for the following forms of "abnormalcy:"

1) Traditionally construed "mental illnesses" (understood as psychical states or physical expressions) constitute part of human "destiny,"
2) When viewed from the spiritual dimension, traditional "mental illnesses," may be accompanied by "spiritual symptoms,"

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[37] See Frankl, *Doctor and Soul,* 191. Frankl claims that the obsessional neurotic "seeks absolute certainty in cognition and decision. He strives for hundred-percentness." As we will see in a later section, Frankl believes that human cognition is fallible and limited. Therefore, the obsessional neurotic misconstrues human nature.

[38] Frankl, *Doctor and Soul,* 195.

[39] Ibid.

3) Uniquely spiritual illnesses may be interpreted as accomplishments or distorted philosophical worldviews.

Underlying these multiple descriptions lies an ambiguous conception of the spiritual dimension of the self.[40]

2c) The tragic triad of human existence: pain, death and guilt

Thus far, attention has been granted to only one philosophical assumption underlying logotherapy, namely the nature of the self. By discussing the theoretical inconsistencies operative in this one, foundational concept it is hoped that the reader may already begin to glimpse how this could impact the practice of logotherapy. At this point, however, the normative force that this concept assumes in the course of therapy has yet to be addressed. This section functions as a bridge by which the reader can begin to see the normative project flourish. At the end, the reader will see how Frankl's description of the person's existential state, consisting of death, pain and guilt takes on a prescriptive force and suggests of its own accord a "particular philosophical worldview."[41]

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[40] In the previous sections, it was shown that logotherapists are warranted in adopting two views of the self. In this section, we have shown that whether or not logotherapists buy into one or the other, they still have an insufficient metaphysical foundation of the spiritual dimension of the self which supports the various diagnoses of mental illness, spiritual illness, etc. More will be said on this when the technique of the logotherapist is discussed.

[41] The unique position that this section occupies can be explained in a slightly different way. In the preceding section, I had suggested that Frankl employs Sartre's existential concept of "facticity," and would agree that it is a person's biological and psychological dimension which constitute destiny. Given the uniqueness of persons, one might assume that each individual experiences their destiny in a highly subjective way. When discussing individual clients, Frankl himself often speaks this way.

In addition, analysis of the tragic triad of our existence bridges together an isolated analysis of the self (subject) to that of the objective realm of values (the other). On the one hand, it characterizes essential features of the person's existence, and therefore, relates to the experience of the self. On the other hand, these features form the backdrop against which human beings act, adopt values, relate to others, etc. At the end of this section, the path will be paved for a discussion of other philosophical assumptions in logotherapy, in particular a discussion of "the objective realm of values." A proper understanding of the descriptions of death, pain and guilt, greatly colors the worldview that logotherapy advocates; for it is against the universal and subjective background whereby all persons exercise free, conscious and responsible action.

Frankl claims that the tragic triad of existence characterizes our "human predicament," but more importantly it *motivates* us to act and to reach out to the objective realm of values.[42] The three aspects which form the "tragic triad of our existence" correlate to each of the ontological dimensions of the self. In some sense, these features can be interpreted as limiting factors of existence. For example, at the somatic level one simply must acknowledge the natural limitation of death. While physical immortality might be a pleasant notion to entertain, all persons have to

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However, for all of the uniqueness of our thoughts and situations, Frankl does find certain features to be characteristic of *all* human destiny. Using Sartrian language, one might call this a general, universalizeable "facticity."

[42] Frankl, *Psychotherapy and Existentialism*, 15 "man's human condition consists of pain, death and guilt."

contend with the inevitability of their own death. Given this, it is quite conceivable how death may act as a motivator to action in the present. Recognition that our lives are limited provides one with a sense of urgency to act in the present moment. While it is rather clear how one's finitude functions as both a limiting factor and a motivator to action, one might very well wonder how this might be explained with respect to pain and guilt. The majority of this section will be concerned with how Frankl understands the concepts of pain and guilt.

Corresponding to the psychological strata of the self is the facticity of pain; corresponding to the spiritual layer is guilt. Unfortunately, Frankl posits these notions and yet says very little about their exact nature -- when they are experienced, how, in what contexts and with reference to what objects.[43] In addition, the proper method by which to examine these so called "realities of our human predicament" is not discussed. Perhaps the method by which these concepts may be investigated is the phenomenological method that Frankl adopts from Scheler. Frankl says:

> We need only turn to the way the man in the street actually experiences meanings and values and translate this into scientific language.[44]

With this method, let us begin with the concept of pain. I believe it is patently obvious that Frankl is not referring to momentary, fleeting, somatic sensations of pain. In this context, since pain is said to be part of our human condition, it must somehow

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[43] Frankl, *Will to Meaning*, 73. "The tragic triad consists of pain, death and guilt. There is no human being who may say that he has not failed, that he does not suffer and that he will not die."

[44] Frankl, *Will to Meaning*, 69.

constitutes a rather permanent aspect of psychological nature. In the abstract and as functioning at the psychological level, one may seek to describe pain as hardship or suffering. But even with this description, pain seems to require an "object." In other words, what is the hardship or suffering about?

There are various ways that Frankl could answer this question. Hardship could be experienced in the face of life in general, in response to other human beings, etc. Frankl himself might be seen to advocate this view given his experiences in the concentration camps and his lengthy analyses of human suffering.[45] Yet, these "outer objects" do not seem to be the proper foundation for a general sense of pain. Life, after all, is not commonly a concentration camp and suffering tends not to define the entirety of our existence. What I am suggesting is that if and only if outer experience could function as the permanent object of our psychological sense of pain, then perhaps it is outer objects which force us to have this tragic existence.

However, I think it is a more plausible way to view pain as constitutive of our psychological nature. In many of his books, Frankl criticizes Freud's notion of the pleasure principle. Two arguments are used: 1) If we wish to claim, as Freud does, that human beings are so constituted as to only pursue pleasure, then we reduce human beings to the level of animals and claim that they are only driven by their instincts, and 2) pleasure can never be aimed at directly for it always eludes the individual.[46]

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[45] See Viktor E. Frankl. *Man's Search for Meaning: An Introduction to Logotherapy,* new and revised ed., trans. by Ilse Lasch with preface by Gordon W. Allport, (New York: Pocket Books, 1963), 3-149.

[46] Frankl, *Psychotherapy and Existentialism*, 63-64.

Pleasure for Frankl, can only be the by-product of completing a task or actualizing a meaning.[47]

I believe that Frankl's real motivation for claiming that pain is part of our psychological tragic existence serves as his ultimate refutation of Freud's psychological hedonism. Unlike Freud, Frankl does not need to claim that human beings are motivated or have a drive toward pleasure; but, by positing pain as part of our facticity he mitigates the idea that there is some one, reductionistic goal that all people seek. It also gives precedence to the will as decider of values, rather than to our instinctual nature. Unfortunately, it leaves Frankl with a decided problem with respect to the goals of logotherapy. For how can one truly feel a sense of happiness or pleasure if a sense of pain is always constitutive of a person's psychological make-up? What sense of joy can possibly result?

If trying to understand the concept of pain were a thorny enough issue, then understanding the concept of guilt becomes even more complex. First, common sense observation does not seem to indicate that *all* people are cognizant of a state of guilt. Once again one wonders what is the proper object of guilt.

For any religious believer, guilt tends to imply a sense of inadequacy, shame or failure with reference to God. In virtue of the fact that Frankl sometimes refers to logotherapy as a "medical ministry" and perhaps because he is Jewish, one might suggest that Frankl superimposed his own sense of guilt onto his psychological

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[47] Sometimes Frankl equates pleasure with happiness. The reader should be aware that Frankl's exact understanding of the nature of pleasure is not central to my argument. For that reason, the reader can construe the meaning of this term as he/she wishes, at least in this section.

understanding of the human person. Textual evidence seems to support this view. Just as Frankl adopts a hierarchical notion of the person, so too does he see this as operating in the disciplines. In *The Unconscious God*, he says:

> Higher dimensions are subsumed by lower ones; Thus biology is overarched by psychology, psychology by noology and noology by theology.[48]

Could it not be the case then, that at the spiritual dimension of being, the human person feels guilt because of his/her fundamental imperfection, failures to God or to prescribed religious action?

There are two reasons as to why this can not be the correct interpretation: 1) Despite his religious alignment, Frankl would never claim that the objective realm of meanings and values are to be equated with religious prescriptions. Religious persons may interpret the values in light of their beliefs; yet, they exist for *all* persons.[49] 2) Frankl contends that while logotherapy may serve as a medical ministry and may orient the person to ultimate meaning, namely God, this is by no means its primary task. It is only a supplementary one if so desired.

Returning to the question at hand: What then is the proper object of guilt? Clearly, guilt can not follow upon our choices. For according to Frankl, when humans are confronted with the objective realm of values, to every situation/question that life poses there is only "one true/right meaning to each situation."[50] Now, if individuals

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[48] Frankl, *Unconscious God,* 13.

[49] Frankl, *Doctor and Soul*, xv.

[50] Frankl, *Will to Meaning*, 60-1.

are choosing the "right" meaning, as Frankl says they must, then clearly guilt does not follow from such a choice.

The only possible answer to this question is that it is the fallibility of conscience itself which is the source of our guilt. The following summarizes the main features of conscience:

> Conscience - is fallible, a human phenomenon, intuitive, creative, its job is to discover values - and the development of conscience is the main goal of education.[51]

If what I suspect is right, then human beings are in a perpetual state of guilt because they realize their imperfection. Sometimes they make the right choices, and conscience is to be the guide of these; sometimes they make the wrong choices and conscience is the guide for these. Guilt remains in either case, for the human condition is such that we lack complete certainty regarding the correctness of our choices.[52] When we embark on a discussion of the goals of therapy -- how one knows when the goals are reached and how one feels when they are reached -- we will see how this precise issue will present Frankl's logotherapy with a major problem.

It might be useful, at this point, to summarize what has been accomplished in this section. One must recall the dual role that the tragic triad of existence is intended to serve in logotherapy: 1) They are limiting factors of the three ontological strata of the

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[51] Ibid., 63.

[52]Admittedly, there is a paradox involved in these two paragraphs. How is it the case that one must always choose the "true" or the "right" meaning in a situation and yet not fully be cognizant (or have a feeling of assurance) that they chose the "true" or "right" meaning? This will be explored in subsequent sections.

human person and 2) They operate as specific motivators to action. In order to clarify their role as limiting factors, it was necessary to explore the very meaning of pain and guilt.[53] It was concluded that since Frankl maintains that pain is a permanent, universal element of the human condition, it would have to be understood "negatively;" that is to say, "pleasure" is not the main goal that persons seek. As for guilt, it was demonstrated that this state pertains to the fallibility of one's own conscience. Let me suggest that it is a small, logical leap to claim that these philosophical features acquire a normative force. Indeed, all persons must contend with death, pain and the fallibility of their own conscience and all human action occurs against the backdrop of these "realities." The worldview which logotherapy advocates begins to "feel" like an enlightened Stoic reality.[54]

With respect to the triad's role as a motivator to action, I find Frankl's account rather bizarre. As noted earlier, perhaps death provides the human person with a sense of "urgency" to act in the present moment. But, it is unclear how a constant privation of pleasure and the unavoidable fallibility of conscience would provide the necessary motivations for one to act. In fact, one could effectively argue that the opposite is true -- the tragic triad may motivate one *not* to act all. For why would one engage in activity if there is a constant, psychological sense of "pain?" And what would be the

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[53] It was noted that it was obvious to see how death would be a limiting factor.

[54] Although not specifically addressed in this section, the "realities" of pain, death and guilt truly acquire their normative force in the actual *practice* of logotherapy. Presumably, a client who is not aware of the tragic triad of his/her existence will have to "acknowledge" it when treated by a logotherapist. This, of course, presupposes that a logotherapist is practicing his craft consistent with the theory.

purpose of action if in the end error is all that is achievable? Frankl's description of the tragic triad is theoretically untenable as a motivational account. In the realm of practice, one must be concerned with how the client who seeks logotherapy is really motivated in their search for meaning.

3) "Logos" (meaning): The objective realm of experience

Throughout this paper, I have baldly been referring to "an objective realm of values" to which the self is related and by which it is constituted. Having analyzed the nature of the self, it is now time to turn to the second half of the equation of the real.[55] Three questions will be considered in this section. They are: a) What is the nature of "logos?" b) How real is "logos?" 3) What are Frankl's proofs for positing "logos?" By the end of this analysis, I will have shown that there is good reason to understand logos as being something far less objective than Frankl intends it to be. At best, Frankl's logos can only honestly be called an inter-subjectively constituted realm of facts and values; at worst, evidence warrants an interpretation of logos as a subjective concept. The theoretical untenability of logos will necessarily lead to practical difficulties for logotherapy.

Throughout this analysis, one must recall one of the reasons which led Frankl to establish logotherapy; namely, it was intended to be a corrective for already existent,

[55] It would be preferable to confine this analysis to a purely descriptive account of the nature of this realm of reality; however, such an exposition will invariably involve the related question of how it is that one knows the nature of these values. Because of this, analysis of the "objective realm of values" may often bring us back to the knowing and acting subject, the self. The reader should be forewarned of the possibility that there is bound to be some overlap in the treatment of these metaphysical descriptions and related epistemological issues.

but inadequate versions of existential analysis/ontoanalysis. While existential analysis was seen to be partially correct in its focus upon the human person as an acting and existent subject, it failed to concern itself with "essence," "logos" or "meaning" -- or that to which the acting subject was related. It is the very presence of "logos" that allowed for existential analysis to be more than mere "analysis" of a subject and to function as a viable form of "therapy" for persons.[57] Both the novelty and central importance that Frankl gives to logos in his theory requires us to consider the nature of the logos and the concomitant issue of its objective/"real" status.

Quite frequently, Frankl simply translates "logos" as "meaning." Construing logos in terms of meaning, at some level, seems to be oxymoronic; for meaning ordinarily is interpreted as something wholly subjective rather than objective. In *The Will to Meaning*, Frankl asserts that "meaning is what is meant, be it by a person who asks me a question or by a situation which too implies a question and calls for an answer.[58] In some sense, the definition itself foreshadows the claim that I want to establish in this section, namely, that the "objective realm of experience" is really permeated with subjectivity at some level. At first glance, one is tempted to interpret "meanings" as belonging to the subjective rather than an "objective" realm. The phrase, "what is meant," seems to hinge upon an individual's interpretation. If there is anything "objective" in that phrase it may be such things as "persons, questions or situations" which *actually exist* and confront individuals. Indeed, in numerous other passages

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[57] Ibid.

[58] Frankl, *Will to Meaning*, 61.

where Frankl speaks of an "objective realm of experience," what seems to be objective are facts/entities, but certainly not meanings. One is led to believe that perhaps it is the facts, properly speaking, that solely constitute an objective realm of experience.[59] The following passage seems to suggest this interpretation:

> Perhaps the law by which man's responsibilities are revealed only in concrete tasks is more general than we imagine. Objective values become concrete duties, are cast in the form of the demands of each day and in personal tasks. The values lying back of these tasks can only be reached for only through the tasks.[60]

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[59] Personal vignettes also seem to suggest this view. For example, in *Man's Search for Meaning*, 58-9, Frankl tells of a personal dilemma that confronted him during World War II. Faced with the choices of remaining with his parents in Vienna or emigrating to the United States, Frankl describes how he made that decision. He says: "While I was pondering what my true responsibility was, I felt that this was that type of situation in which you wish for what is usually called a hint from Heaven. Then I went home and when I did so, I noticed a piece of marble stone lying on a table. I inquired of my father how it came to be there, and he said: "Oh, Victor, I picked it up this morning at the site where the synagogue stood." (It had been burned down by National Socialists.) "And why did you take it with you?" I asked him. "Because it is a part of the two tables containing the Ten Commandments." And he showed me, on the marble stone, a Hebrew letter engraved and gilded. "And I can tell you even more," he continued, "if you are interested; this Hebrew letter serves as the abbreviation of only one of the Ten Commandments." Eagerly I asked him, "Which one?" And his answer was: "Honor father and mother and you will dwell in the land." On the spot I decided to stay in the country, together with my parents, and let the visa lapse."

I believe that this story offers way to see how logos may be construed as "objective." In Frankl's view, it was the fragment of the Torah which was the very carrier of "values." By way of concluding the account, Frankl denies that this story could be interpreted as a projective test and says: "... the only thing which is subjective is the perspective through which we approach reality, and this subjectiveness *does not in the least detract from the objectiveness of reality itself*" (emphasis added, mine).

[60] Frankl, *Doctor and the Soul*, 41-2.

While it is tempting to create a sharp divide between facts and meanings with the hope of getting clear as to what exactly is objective and subjective, facts/objects are inextricably intertwined with meaning. So, the logos that was earlier referred to does not by itself constitute some outer objective realm of experience; but rather, meaning(s) exist in conjunction with a multitude of facts/events. Together, these constitute the objective realm and confront the individual. At this point, our conception of the objective realm of experience can even be broadened to include facts, meanings and values; for values are only "... meaning universals which crystallize the typical situations a society or even humanity has to face."[61] Inadvertently, we have achieved a full description of *what* constitutes the objective realm of experience: facts/events/situation, meanings and values. Now we will turn to a consideration of the phenomenological proofs that Frankl offers for this view.[62]

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[61] Ibid., 56.

[62] I imagine that one could claim that Frankl's negation of Sartre's relativism and subjectivism serves as a *kind* of proof for the objective realm of values. For Sartre, persons confront their existential situation (facticity). Through action, persons create both their individual essence, and a model for how all human persons should be. Frankl finds this view untenable, so much so, that he claims it reminds him of the Fakir trick (see *Will to Meaning,* 60). However, Frankl rejects Sartre's view by insisting that "what man so badly needs in order to preserve mental health and wholeness is that the objectiveness of the objective pole be preserve" (*Will,* 61). As one can see, Frankl's argument is really no argument at all. Rather, he just uses different starting points or assumptions than does Sartre. In short, Frankl does not directly provide the reader with proof that Sartre's view is wrong, but only that it fails to lead an individual to mental health/wholeness. While disproving Sartre's existentialism may be peripheral to the grounding of logotherapy, demonstrating that the objective realm of values exists is not. It is the existence of this realm that allows persons to have mental health and also, which allows logotherapists to cure the spiritual sufferer.

There are at least four lines of reasoning Frankl uses in order to legitimate this objective realm of experience. They are:

> Unless self-understanding is crippled by pre-conceived patterns of interpretation, not to say indoctrination, he refers to meaning as something to find rather than something to give. And a phenomenological analysis which attempts to describe such an experience in an unbiased and empirical way will show us that, indeed, meanings are found rather than given.[63]
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> The particularity of all perspective, the fragmentary nature of all images of the world, after all presupposes the objectivity of the world.[64]
>
> The ultimate -- or, if you will, the first -- question of radical skepticism is about the meaning of existence. But to ask the meaning of existence is meaningless in that existence precedes meaning. For the existence of meaning is assumed when we question the meaning of existence.[65]
>
> Value is transcendent to the act which intends it. It transcends the value-cognitive act which is directed toward it, analogous to the object of an act of cognition, which likewise is situated outside of this (in the narrower sense of the word cognitive) act. Phenomenology has shown that the transcendent quality of the object in the intentional act is always already present in its content. If I see a lit lamp, the fact that it is there is already given along with my perception of it, even if I close my eyes or turn my back to it. In the perception of an object as something real is already contained the implication that I recognize its reality independently of its perception by myself or anyone else. The same is true of the objects of value perception. As soon as I have comprehended a value, I have comprehended implicitly

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[63] Frankl, *Will to Meaning*, 61.

[64] Frankl, *Doctor and Soul*, 16.

[65] Ibid., 196.

> that this value exists in itself, independent therefore of whether or not I accept it.[66]

I have quoted the above passages at length, not with the intent of assessing the validity of these proofs, but rather, to assess how real (or what kind of reality) the objective realm of values has according to Frankl. Frankl forthrightly states that the proof for this realm is derived from the phenomenological tradition. For this reason, a brief excursion into the phenomenological tradition may well be justified.

It is a basic strategy of all who call themselves "phenomenologists" to begin with the brute fact of experience and the knowing subject. In addition, phenomenology aims to discover meanings/essences of experience. But essences are equally constituted by "acts of consciousness" and by what experience presents us with. To some, such as myself, a phenomenological theory of meanings seems to order upon a version of idealism. By implication, this understanding of phenomenology would render it impotent with respect to claims about mind-independent reality. However, one should bear in mind that the proof for the logos of Frankl's logotherapy draws much more from the work of Max Scheler than that of Husserl. Scheler, in greater degree than Husserl, would say that the place where meanings are discovered lies with the object and not with the knowing/perceiving subject. Or, "meaning is given to consciousness with the sense data and essences are carried by objects."[67] By way of summary: 1) all phenomenologists begin with experience, 2) to know what experience

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[66] Ibid., 40-1.

[67] Eugene Kelly, *Max Scheler,* Twayne's World Leaders Series, vol. 55, (Boston: Twayne Publishers, 1977), 32.

is assumes both a "something (meaning or an object)" and a knower (subject),[68] but 3) unlike Husserl, Scheler and Frankl are far more insistent about the permanence/reality of essences that "impinge" upon the mind of the knower. In the end, the question will be can the nature of this realm be substantiated *according to their own criteria*?[69]

In some sense, the very fact that Frankl establishes his claims for an objective realm of values within the phenomenological tradition mitigates interpreting his theory as a version of objective realism.[70] More honestly but less frequently, Frankl seems to admit that the objective realm of values is only "phenomenologically real" and consists of only "trans-subjective meanings/values." If this is the case, as it seems to be, one could simply end this account by claiming that Frankl was inconsistent with his language. Rather than referring to an "objective" realm of values, he should have

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[68] Ibid.

[69] It should be noted before moving on that the potential error of interpreting "existence" as subjective and essence as "objective" has been tempered. Even though Frankl all-too often makes use of the term "objective" which might imply that persons can have knowledge of reality-in-itself, phenomenological proofs mitigate this interpretation. All experience is always experience relative to the observer. For this reason, Frankl occasionally refers to logos more correctly as "trans-subjective" reality. This phrasing better explains the meaning behind passages such as: "We must remain aware of the fact that as long as absolute truth is not accessible to us (and it will never be), relative truths have to function as mutual correctives. Approaching the one truth from various sides, sometimes even in opposite directions, we can not attain it, but we may at least encircle it" (*Doctor and Soul*, xiii). Given this view of reality, one might say that Frankl is really a relativist in a foundational sense. It appears as if Frankl is solely describing "phenomenological reality" as opposed to "objective reality." For an explanation of "phenomenological reality," see Manfred Frings, *Max Scheler*, 2nd ed., (Milwaukee: Marquette University Press, 1996), 20.

[70] By using the term, "objective realist," I have in mind traditional metaphysicians such as Plato or Descartes who believed that there is a reality which exists independently of the conceiver.

consistently referred to it as a trans-subjective realm of experience. This section could, then, conceivably end here.

However, let me suggest that even if we charitably overlook Frankl's inconsistent use of language, the above quotations still leave us with questions of the following: With respect to the first citation, one may very well wonder how empirical and unbiased Frankl's assessment is of the realm of experience.[71] Granted that there *is* a trans-subjective realm of experience consisting of meanings/values and facts taken together, is it possible to claim that there is more (and we can know more of it) than that? Considering this question will serve as a further explanation of the "reality" of the "trans-subjective" realm of values as well as function as a natural bridge to the next section on epistemological considerations. In other words, barring the question of existence, is it the case that a hierarchy of values can truly be discerned from a trans-subjective realm of values?

Frankl, following in the footsteps of Scheler, maintains that within the realm of experience there exists a hierarchy of values. Values, for both Scheler and Frankl are of one of two kinds: eternal or situational. The criteria for this distinction could be described in various ways. Eternal values are somehow "more binding," more universal" more enduring and often called "higher" on the scale of values when

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[71] Again, the reader must bear in mind that this question is not only theoretically significant, but also, it is of great practical importance. As noted at the outset of this section, logotherapy was introduced as a corrective to inadequate versions of existential analysis. It was due to the introduction of "logos" that allowed existential analysis to truly become a viable form of "therapy" rather than mere "analysis."

compared with situational values. While Scheler proceeds to identify four kinds of values from this fundamental distinction,[72] Frankl's hierarchy consists of three, different values. The following quote identifies his schema and reminds us, curiously, of the "empirical" method that yielded this "unbiased" data.[73] He says:

> The logotherapist is neither a moralist nor an intellectual. His work is based on empirical, i.e. phenomenological analyses, and a phenomenological analysis of the simple man in the street's experience of the valuing process shows that one can find meaning in life by creating a work or doing a deed or by experiencing goodness, truth and beauty, by experiencing nature and culture; or, last but not least, by encountering another unique being in the very uniqueness of this human being -- in other words, by loving him.[74]
>
> If one prefers in this context to speak of values, he may discern three chief groups of values. I have classified them in terms of creative, experiential and attitudinal values. This sequence reflects the three principal ways in which man can find meaning in life. The first is what *he gives* to the world in terms of his creations; the second is what *he takes* from the world in terms of encounters and experiences; and the third is *the stand he takes* to his predicament in case he must face a fate which he cannot change.[75]

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[72] W. Stark, ed., introduction to *The Nature of Sympathy*, by Max Scheler, trans. by Peter Heath, (Hamden, Connecticut: Archon Books, 1973), xvi. The values are: a) holiness, b) spiritual/cultural values, c) vital values and d) pleasure values.

[73] I do not believe it is an arbitrary point that the three categories of values naturally correspond to Frankl's dimensional view of the self. The fact that attitudinal values are the deepest and most important kind of values that can be achieved seems to underscore the correctness of my interpretation that the spiritual core of the self is the foundational and most important aspect of the self.

[74] Frankl, *Will to Meaning,* 69.

[75] Ibid., 69-70. For a further description of creative, experiential, and attitudinal values, see Frankl's *Doctor and Soul*, 43-4.

There are two important conclusions that result from considering a phenomenological analysis and categorization of values. First, both Scheler and Frankl must admit that to claim that values are "trans-subjective" opens their theories up to the charge of relativism at some level. Secondly, and moreso than Scheler's categorization, Frankl's definitions refer obviously and implicitly to human subjectivity. In virtue of the fact that creative and attitudinal values find their origin within the individual and are specifically values of individuals (as opposed to groups of individuals), the logos of logotherapy seems to be far more radically subjective than trans-subjective.

So as to side-step the charge of relativism, both Frankl and Scheler appeal to the defense of perspectivism.

> He compares the eternal and immutable values to a mountain range which towers high above the valleys in which we humans live. To every age and to every people they reveal, according to their respective points of view, a different aspect of themselves: each one is true, and yet each one is unacceptable to all the others. We must not speak of a relativism of values then, but rather of a perspectivism (314) - an altogether different proposition.[76]

> ... the only thing which is subjective is the perspective through which we approach reality, and this subjectiveness does not in the least detract from the objectiveness of reality itself. I improvised an explanation of this phenomenon for the students in my seminar at Harvard. "Just look through the windows of this lecture hall at Harvard Chapel. Each of you sees the chapel in a different way, from a different perspective, depending on the location of your seat. If anyone claimed that he sees the chapel exactly as his neighbor does, I would have to say that one of them must be hallucinating. But does the difference of views in

[76] Stark, introduction in *Nature of Sympathy*, xvii.

> the least detract from the objectivity and reality of the chapel? Certainly it does not.[77]

It seems highly dubious to me to suggest, as Kelly does, that perspectivism is somehow an altogether different proposition from relativism. But even if somehow it is, it appears as if Scheler's hierarchy of values is more amenable to this interpretation. On Frankl's categorization, only the experiential values of truth, beauty and goodness are of the kind that may be "seen" through a particular perspective. Creative and attitudinal values, by contrast and by definition, are of the sort that are rooted in human subjectivity. An additional concern of "perspectivism" is that the criterion by which trans-subjective values are found is, as has been noted, by consulting how the ordinary man in the street behaves. Perhaps even the limited category of experiential values, then, have subjectivity as at their root, being nothing more than consensually agreed upon values.

Summarizing what has been accomplished in this section, it has been shown that in logotherapy, the objective realm of experience consists of an inextricable combination of facts and values. Nonetheless, the "objectivity" of this realm really is only "trans-subjectively" or phenomenologically real. Definitions of the supposed hierarchy of values reduces itself to two categories of values which really have their basis in human subjectivity. The only category of values which somehow retains its "trans-subjectivity" are experiential values. Even so, this category of values does not escape the charge of being relative by appealing to perspectivism as a defense. This is

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[77] Frankl, *Will to Meaning,* 59-60.

especially true when one considers the criteria by which values are "discovered," namely by consulting how the man in the street behaves. If the objective logos is permeated with subjectivity and therefore *is* relative at some level, why, one wonders, is Frankl insistent that the logos is objective?

The philosophical answer might be that it simply serves as a corrective to a misguided philosophical theory, namely Sartre's. Perhaps the real reason why Frankl does this is to argue that life is not absurd; or, one might say, even if one thinks life is absurd meanings still exist in spite of such a perception. But more importantly, Frankl does want to make room for morality. Our contemporary society which is characterized by a loss of meaning and in which many people find themselves in an existential vacuum signals the possibility of further corruption -- corruption that we bore witness to in Nazi Germany. An objective realm of values allows for a standard by which the likes of Hitler could be judged and be deemed a failed human being.

4) How we know the objective realm of experience: the role of intuitive conscience

In this section, I will focus on the nature of intuitive conscience or the means by which an individual can be said to know the objective realm of values. By necessity, my analysis of intuitive conscience will be confined to three issues: a) How is it possible that one discovers the one/true meaning in a situation if conscience by definition is fallible? b) What motivates "intuitive conscience" to discover trans-subjective values? c) A problem with the causal story and motivational story.

A basic description of the role of intuitive conscience is required if one is to understand how it is that an individual discovers the trans-subjective realm of values. Again, this issue has both theoretical and practical importance; for if the logotherapist is neither to be construed as a moralist nor as an intellectual, then by default, it will be the client's own conscience that allows her to know the trans-subjective realm of values and to achieve "meaning." Frankl is unusually specific when it comes to describing the central features of intuitive conscience. Nonetheless, I will show that there is an obvious discrepancy in the description and the role of conscience itself. Since this is a theoretically difficult issue, it is likely to raise concerns about the logotherapist's theoretical understanding of this concept and practical applications of it.

In *The Will to Meaning,* Frankl offers the following definition of conscience. He says: "conscience could be defined as the intuitive capacity of man to find out the unique meaning of a situation." In addition, conscience is creative insofar as it has the "power to discover unique meanings that contradict accepted values;" it is "human phenomenon and because of this it is fallible;"[78] Two consequences follow from the

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[78] Consider the following descriptions of conscience put forth by Frankl, in *The Will to Meaning:* "Apart from being intuitive, conscience is creative. Time and again, an individual's conscience commands him to do something which contradicts what is preached by the society to which the individual belongs," 63. "Conscience also has the power to discover unique meanings that contradict accepted values," 63. "Because we live in an existential vacuum, or a place where values are on the wane, education can not afford to proceed along the lines of tradition, but must elicit the ability to make independent and authentic decisions... a lively and vivid conscience is what resists the effects of conformism and totalitarianism," 64-5. "True conscience has nothing to do with what I would term 'Superegotistic pseudomorality.' Nor can it be dismissed as a conditioning process. Conscience is a definitely human phenomenon. But we must add that it is also "just" a human phenomenon. It is subject to the human condition in that it is stamped by the finiteness of man. For he is not only guided by conscience in his search for meaning, he is sometimes misled by it as well. Unless he is a perfectionist,

definitions.[79] First, I would suggest that the very fact that conscience is "creative" subtly adds credence to my previous interpretation of the trans-subjective realm of values as radically subjective and/or simultaneously further erodes the reliability of "looking at the common man in the street's behavior" as a criteria for making decisions. Although Frankl wants to claim that the "creative" capacity of conscience is to *discover* unique meanings, if our criteria for discovery is empirical (and sometimes this empirical evidence may be misguided or in need of correction), then an *individual's* conscience is given precedence as the criterion for decision-making. Thus, at least in logotherapy, while empirical evidence is sometimes referred to as the guide for discovering phenomenologically real values, it is human conscience which acts as the ultimate arbiter in decision-making.

A second, but even more significant problem is readily apparent in Frankl's description of conscience. Conscience is a human phenomenon and as such, it is a fallible guide. But, in spite of this permanent possibility of fallibility,[80] Frankl insists that in each situation, there is always *one right* and *one true* meaning to be found. Frankl himself seems to be well aware of the oddity of these two claims; but nonetheless, he defends them as follows:

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he will also accept this fallibility of conscience," 65. "But if man is not to contradict his own humanness, he has to obey his conscience unconditionally, even though he is aware of the possibility of error," 66.

[79] Frankl, 63.

[80] One must recall what was said in the analysis of the tragic triad of human existence. The fallibility of conscience is said to be part of human facticity.

> On one of my lecture tours through the United States my audience was requested to print questions in block letters for me to answer and hand them over to a neurologist who passed them over to a theologian who passed them on to me. The theologian suggested that I skip one, for as he said, it was "sheer nonsense. Someone wishes to know," he said, "how you define six hundred in your theory of existence." When I read the question I saw a different meaning. "How do you define GOD in your theory of existence?" Printed in block letters, "GOD" and "600" were hard to differentiate. Well, was not this an unintentional projective test? After all, the theologian read "600," and the neurologist read "GOD." But only one way to read the question was the right one. *Only one way to read the question was the way in which it was meant by him who had asked it.* (emphasis added mine) [81]

> To be sure, man is free to answer the questions he is asked by life. But this freedom must not be confounded with arbitrariness. It must be interpreted in terms of responsibleness. Man is responsible for giving the right answer to a question, for finding the *true* meaning of a situation. And meaning is something to be found rather than to be given, discovered rather than invented. Crumbaugh and Maholick point out rather that finding meaning in a situation has something to do with a Gestalt perception. This assumption is supported by the Gestaltist Wertheimer's statement: "The situation, seven plus seven equals... is a system with a lacuna, a gap. It is possible to fill the gap in various ways. The one completion -- fourteen -- corresponds to the situation, fits the gap, is what is structurally demanded in this system, with its place, in the function of the whole. It does justice to the situation. Other completions such as fifteen, do not fit. They are not the right ones. We have here the concepts of the demands of the situation; the 'requiredness.' "Requirements of such order are objective qualities."[82]

I quote these passages at length in order to demonstrate how Frankl defends this idea that there is only one true or right answer to be given in a situation, in spite of the

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[81] Frankl, *Will to Meaning,* 61-62.

[82] Ibid.

fallible nature of conscience. In the first quote, while Frankl admits that at least two interpretations are possible, the "right" meaning is precisely "that which is intended by him who asked the question." This proviso is interesting for at least in that situation, one has a way of determining the correctness of the interpretation. Assuming that the individual had a specific intent in asking the question and not wanting to be deceptive, one need only ask the person in order to discover the "truth" or "rightness" of *his meaning* of the question. However, when one considers the plethora of situations, facts, events, persons, meanings, objects, etc. that constitute the "objective realm of experience," it is certainly not as obvious what the criteria might be for checking the truth or correctness of our interpretation. It is even difficult to imagine what the criteria might look like in order to carry out this investigation.

Fortunately, Frankl's second, mathematical example offers us a hint. The number, "fourteen," we are told, is the *right* response precisely because it fits the situation and does *justice* to the equation. However, I would contend that the number fits the situation because the rules of addition determine what number must necessarily fill the gap. By analogy, and in the realm of experience, one must say that there are "experiential rules" which determine how persons ought to behave in certain situations. But, whereas it seems plausible to suggest that these experiential rules are only "social rules" (and therefore, human creations and inter-subjectively constituted), Frankl misleadingly identifies them as "requirements" which are "objective qualities." A bit later, these requirements are compared to "social rules" and are explained as follows:

> Today, we live in an age of crumbling and vanishing traditions. Thus, instead of new values being created by finding unique meanings, the reverse happens. Universal values are on the wane... However, even if all universal values disappeared, life would remain meaningful since the unique meanings remain untouched by the loss of traditions.[83]

Care has been taken with terminology in this section because there are at least two different places and two kinds of criteria that one may use in order to discover the true or right answer to a situation. On the one hand, one may use common-sense observation and consult traditions. In this way, one will *necessarily* find the true and right meaning of a situation. On the other hand, if the rules can not be discerned (either because there is no clear social rule, or by the discovery that the rule is somehow wrong), then conscience must act in its creative capacity and discover the true/right answer. The following issues are neither explained nor acknowledged by Frankl: when one should consult what proper object and/or with what concomitant epistemological criteria; the intelligence that a person must have in order to enact these mechanisms; the inherent inter-subjective origins of the basis of "traditions." With such variability, one wonders how an individual (let alone a logotherapist who purports to have expertise in this area and help people find these answers) is really capable of discovering the true/right meaning of a situation.[84]

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[83] Ibid., 64.

[84] These issues will be shown to be especially disconcerting when it comes to the practical application of logotherapy. For, acknowledging that "spiritual illnesses" can and do occur, how is it the case that a client can mobilize his "conscience" in order to effectively assess existent traditions, let alone to discover unique meanings? In addition, is it the case that the logotherapist (again, by the theory itself advocating these two, disparate ways of knowing) can neither be a "moralist" nor an "intellectual" in his practice? This footnote can only scratch the surface of this topic. A further

Perhaps, the answer to the above dilemma lies with the "intuitive" nature of conscience. A rough and ready definition of "intuitionism" is that persons have a direct and immediate grasp of some reality.[85] Frankl often equates one's intuitive ability with having the capacity to "sniff out values." Our concern in this section will be to assess whether intuitive conscience finds its basis in the emotive or cognitive realms for Frankl. In short, leaving aside the very real question of whether or not intuition constitutes a valid criteria for knowledge, I want to consider the motivational account lying behind Frankl's understanding of conscience. Is it feeling that motivates an individual toward meaning; or rather, is it consciousness itself?

Understanding what motivates an individual toward meaning is crucial for both the theory and practice of logotherapy. For, if the intuitive aspect of conscience is grounded at the emotive level, this would seem to imply that it is the psychological aspect of the self which motivates action. If the three layers of the self are

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analysis will follow in subsequent sections.

[85] As an anticipatory point, it seems likely that many persons consult psychotherapists because they lack, or think they lack, a direct grasp of reality. Frankl says as much in *The Doctor and the Soul*: "the neurotic lacks an instinctive sureness," 14. Given this, is it not the case that the logotherapist acts in the capacity as either an intellectual or moralist when reinstilling an instinctive sense of sureness for the neurotic?

In other passages in *Doctor and Soul*, Frankl says that the logotherapist's role is to evaluate the *appropriateness* of the neurotic's worldview. He says: "Suppose the patient's world-view should turn out to be a valid one. In that case we would be committing a serious error in opposing it, for we must never leap to the conclusion that a neurotic's world-view is necessarily wrong simply because it is neurotic. However, it may happen that the patient is wrong in his world-view. In that case, *correcting* it calls for non-psychotherapeutic methods. .... *We must still refute it* [the worldview]... *Our evaluation* of ideas does not depend on the psychic origin of those ideas (emphasis added, mine), 14-15.

ontologically distinct, how is it the case that emotions "cause" free decision? I think this is important because Frankl is insistent that persons are always capable of taking a stand toward their psychological distress. Yet, if it is the case that emotions are what motivates and causes free action, and if persons suffer at the psychological level, how is free (conscious and responsible) action possible in logotherapy? What would motivate or cause a psychological sufferer to take a stand at all?

There is some evidence that Frankl understands the "intuitive" part of conscience as rooted in emotion. In *The Unconscious God,* Frankl characterizes the "intuitive" nature of conscience as follows: An intuitive conscience is one that is "prelogical," "irrational," and "it is based in the emotional and intuitive."[86] He also claims that the intuitive conscience is rooted in "love." Love is a complex emotion and might be said to have both a psychological and cognitive component. Could persons have a conscious awareness of love that acts as a motivator and cause of action? Gould thinks that this is where Frankl draws from Scheler and bases intuition on the feeling of love.

However, there is some ambiguity as to whether or not love is the proper motivator to action. This ambiguity occurs in several places in *Man's Search for Meaning.* To begin with, Frankl recounts the story of how he endured his suffering in the concentration camps by contemplating his wife. He says:

> A thought transfixed me: For the first time in my life, I saw the truth as it is set into song by so many poets, proclaimed as the final wisdom by so many thinkers. The truth that love is the

[86] Frankl, *Unconscious God,* 37.

> ultimate and the highest goal to which man can aspire. Then I grasped the meaning of the greatest secret that human poetry and human thought and belief have to impart: *The salvation of man is through love and in love.*[87]
>
> In this respect, conscience is like love-- the reason for this comparison is that both have to do with something that is absolutely unique.[88]
>
> Even if a man has never loved or never been loved, he may still realize values.[89]

So, perhaps love is not the basis of the intuitive conscience which moves us toward the objective realm of values. It can not be a psychological force such as an instinct or a desire - this would imply that the person is driven.[90] Sometimes, Frankl speaks as if the pull from the objective realm of values pushes the individual toward them (find quotes) -- but this still leaves us with the problem of individual engagement. What after all, would make an individual *want* to realize an eternal value in a certain situation? This type of justification really poses a problem for us when one recalls from the previous section that it is only experiential values, and not creative or attitudinal values, that can provide this "pull."

Whether or not Frankl definitively asserts that love, feelings, etc. is the basis for the intuitive part of conscience and is far from clear. However, let me suggest, that if this were to be the case, then the theoretical and practical problem exists concerning

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[87] Frankl, *Man's Search,* 58-59.

[88] Ibid., 34.

[89] Frankl, *Psychotherapy and Existentialism,* 75.

[90] William Blair Gould. *Viktor Frankl: Life with Meaning,* (California: Brooks/Cole Publishers, 1993), 90.

what *motivates* individuals toward meaning. Conversely, if love, feelings, emotions, etc. are *not* the basis for intuitive conscience, the only possible explanations for why individuals are motivated to act is either an abstract sense of duty rooted in conscience and/or the objective realm of values itself. If either of the latter are intended to explain human motivation, then, from a practical point of view, it would be very difficult to see why individuals seek logotherapeutic help. Why, after all would a logotherapist even be consulted if conscience can discover the objective realm of values and this realm of values alone provides sufficient motivation for an individual drive toward meaning?

Let us now turn to a consideration of how these competing motivational accounts may impact logotherapeutic practice. To begin with, almost all of Frankl's case studies suggest that people enter therapy for relief of pain. Both of the novel techniques of logotherapy, namely, dereflection and paradoxical intention have as their main aim the relief of *psychological* suffering.[91] However, one must remember that the stated goal of logotherapy is for persons to actualize meaning(s) or value(s). Ironically, Frankl's case studies repeatedly indicate that, if not brute pleasure, at least some kind of relief of suffering is what *actually* motivates human beings both to seek logotherapeutic treatment and may in fact function as the end goal of therapy itself. If

[91] It is not necessary that I be very careful about my language at this point because I am solely establishing that the techniques of dereflection and paradoxical intention in no way address an individual's search for meaning. By definition, these techniques only aim to relieve psychological suffering or pain.

this is actually the case, then theoretically some sort of psychological motivation would have to be presupposed on the part of those who seek logotherapeutic help.

If on the other hand, Frankl's motivational account is really rooted in an abstract duty of conscience or if the objective realm of values itself provides the necessary motivation to seek meaning, then logotherapy, I would argue, really becomes something of an abstract, intellectual affair. Detailed, selection criteria of candidates would seem to be required; for, if clients fail to have a certain amount of intelligence to cognize "abstract/eternal" values, or if they do not understand their duties, then logotherapy, in principle could not be effective. In other words, certain kinds of clients, by definition, could not be treated by logotherapy.

Either motivational accounts raise some curious issues for the practitioner of logotherapy. I have repeatedly cited Frankl's assertion that the logotherapist is "neither a moralist nor an intellectual." If the first motivational account is correct and clients do seek relief from psychological suffering then, at the very least, I would argue that the logotherapist is *both* a moralist or an intellectual. For, expertise in the application of the techniques of paradoxical intention and dereflection is assumed, (hence, the intellectual role); and because a value is the aim of the technique, then that would be a sufficient requirement to demonstrate that the logotherapist is a moralist.

However, even if the second motivational account is correct, then there is still reason to believe that the logotherapist is *both* an intellectual and a moralist. First, and as acknowledged earlier, it would be difficult to see why a client who has sufficient intelligence and a sense of duty would be motivated to seek help from a

logotherapist. What, after all, would a logotherapist do for them? But, indeed, if such a client does seek such treatment in logotherapy, then the logotherapist would be acting as an "intellectual" or as Frankl sometimes says as an "opthamologist" by trying to get the client "to see the world as it really is."[92] In this way, the logotherapist is somehow clarifying the nature of the objective realm of experience.

5) Bridge: What has been accomplished thus far?

By way of a reminder to the reader, the purpose of this chapter has been to identify the philosophical assumptions in logotherapy and to demonstrate the normative force that they acquire in the context of therapy and for the goals of treatment. Indeed, much of the above analysis has shown how a clear understanding of the very philosophical notions has been difficult to achieve. This being the case, a coherent account of the normative force of these assumptions -- resembling perhaps a consistent ethic of logotherapy -- seems to be a pipe-dream.

At the beginning of this chapter, I claimed that I would show how relativism, in a variety of senses, lurks beneath logotherapy. I have argued that consistently there is ambiguity in the meaning of logotherapy's foundational assumptions, specifically with respect to the purpose of this form of therapy, the definition of the nature of the person, the nature of the objective realm of values, etc. Recalling the architectural metaphor used at the beginning of this chapter, this kind of semantic relativism has two important implications for practice. First, the meaning of the assumptions is

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[92] Frankl, *Psychotherapy and Existentialism,* 57.

relative to the individual interpretations of the practitioners of logotherapy.[93] Secondly, the goals that clients are said to achieve at the end of therapy are relative to the practitioners understanding of the purpose and techniques of logotherapy.

As they occur in the actual clinical encounter, these various senses of relativism will be explored in the remaining section of this chapter. The clients of logotherapy will be the next subject to be considered, specifically: a) analysis of clinical neurotics and b) analysis of existential neurotics.

6) The therapeutic encounter
6a) Treatment of the clinical neurotic

It is important to stipulate at the outset that when I refer to the clients of logotherapy, I refer only to those individuals who are being seen for some extended period of time (more than 2 occasions) and on an individual basis by a practitioner of logotherapy. This stipulation is essential because Frankl admits that logotherapy may legitimately be said to have many different applications, in many different contexts and

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[93] Some might wish to challenge my claim and say that Frankl acknowledges the fact that the particular individuality of the psychotherapist will enter into the confines of therapy. In *The Doctor and the Soul*, 280, he says: "All psychotherapy is ultimately something of an art. There is always an irrational element in psychotherapy. The doctor's artistic intuition and sensitivity is of considerable importance. The patient, too, brings an irrational element into the relationship; his individuality. ... it is questionable whether there can ever be the `correct psychotherapy.' Is there not rather a correct psychotherapy practiced by a particular doctor upon a particular patient? At any rate, psychotherapy resembles an equation with two unknowns -- corresponding to the twin irrational factors." However, Frankl's admission in no way challenges my claim that individual -- and perhaps "irrational" -- interpretations enter the confines of therapy because of the theory itself. Frankl would never admit to this.

for various numbers of people.[94] This stipulation, will allow for greater precision when selecting the case analyses to be discussed and greater clarity in seeing what are the goals of a an application of logotherapy.

When delimited in this way, clients deemed suitable for logotherapy are those who suffer from "neurosis," either of the existential or clinical sort.[95] Irrespective of the distinction, and in light of Frankl's dimensional view of the person, it is the spiritual aspect of the person which receives focused attention in the confines of logotherapy. This is the hallmark of logotherapeutic treatment and differentiates it, in Frankl's view, from other forms of psychotherapy.[96]

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[94] Frankl, *Doctor and Soul*, 279: "In these cases logotherapy is a specific therapy; in other cases, it is a non-specific therapy. That is to say, there are cases in which ordinary psychotherapy must be applied and yet a complete cure can be effected only by logotherapy. There are also cases in which it is not a therapy at all, but something else which we term medical ministry. As such, it is to be used not only by the neurologist or the psychiatrist, but by every doctor. The surgeon, for example, needs to minister to his patient when he is faced with an inoperable case, or when he must cripple the patient for life by amputating a limb. The orthopedic surgeon faces similar spiritual problems; so does the dermatologist who deals with disfigured cases, the general practitioner who must treat permanent invalids." See also, Frankl, *Man's Search,* 127-33, on the opportunities for collective psychotherapy within the concentration camp.

[95] Frankl, *Doctor and Soul*, xvii: "In this sense despair over the meaning of life may be called an *existential neurosis* as opposed to *clinical neurosis*. Just as sexual frustration may -- at least according to psychoanalysis -- lead to neuroses, it is conceivable that frustration of the will-to-meaning may also lead to neurosis. I call this frustration, *existential frustration.*"

[96] Frankl, *Doctor and Soul*, 181: "...for when one interprets the symptom ultimately as a mode of existence, as a sort of spiritual attitude, the groundwork has been laid for logotherapy as a specific treatment."

We may begin by focusing on clinical neurosis. A cursory list of the names of these kinds of mental illness may ring familiar, for they appear to be standard psychological descriptions of illness. They are: anxiety neurosis, obsessional neurosis, melancholia and schizophrenia. It is worthwhile to quote one description of this type of illness at length in order for the reader to get the flavor of how clients suffering from clinical neurosis may be viewed as potential clients for logotherapy:

> Like all other neurosis, obsessional neurosis also has a constitutional basis. Wexberg and others, whose interest lie mainly in the fields of psychogenesis or psychotherapy, have assumed that a somatic substructure ultimately underlies obsessional neurosis. A number of clinical pictures had been observed in which postencephalitic behavior showed striking similarities to obsessional neurotic syndromes. The mistake was made of confusing similarity in form with identity in nature.
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> An "anankastic syndrome" was considered to be the hereditary element in obsessional neurosis; it was believed to have special genetic radical which was supposedly dominant. Finally, it was proposed that the term "obsessional disease" be used instead of "obsessional neurosis," in order to stress the constitutional quality of the illness.
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> As far as therapy is concerned, these various views strike us as largely irrelevant. Moreover, to make much of the constitutional factors underlying obsessional neurosis does not relieve psychotherapy of its obligation, nor deprive it of its opportunities. For anankasm consists of nothing more than a mere disposition toward certain characterological peculiarities such as meticulosity, exaggerated love of order, fanatical cleanliness, or overscrupulousness -- traits which, in fact, must be recognized as culturally valuable. They do not seriously incommode the person who has them or those around him. They are only the soil in which the actual obsessional neurosis can grow, though it does not necessarily do so. Where such a constitution does give rise to a neurosis, human freedom is involved. Revealing the psychogenic nature of the particular neurotic content need not be therapeutically effective, nor is it indeed even indicated. On the contrary, detailed treatment of symptoms in obsessional neurotics would only give encouragement to their compulsion to brood over their symptoms.

> We must, however, distinguish carefully between such symptomatic treatment and palliative treatment by logotherapy. The logotherapist is not concerned with treating the individual symptom or the disease as such; rather, he sets out to transform the neurotic's attitude toward his neurosis. For it is this attitude which has built up the basic constitutional disturbance into clinical symptoms of illness. And this attitude, at least in milder cases or in the early stages, is quite subject to correction. Where the attitude itself has not yet taken on the typical obsessional-neurotic rigidity, where it is not yet infiltrated, so to speak, by the basic disturbance, a change in its direction should still be possible.[97]

There are several issues that are important to highlight from this one example of a clinical neurosis. However, the most important feature to recognize is that *all* aspects of the human person are said to contribute to the neurosis -- physiological, psychological and spiritual components. Nonetheless, what is deemed important *from a logotherapist's point of view* is the spiritual aspect of the illness -- both as a way for making the diagnosis and in circumscribing the proper focus of treatment.

The exclusivity of logotherapy's focus is odd, indeed, when one considers that both the *cause and the cure for the illness* are rooted in a person's spiritual dimension of being. As stated above, "human freedom is involved" in the illness; yet, human freedom is precisely the aspect by which one's illness can be cured. As Frankl states: "Obsessional neurosis is not a psychosis; the sick person's attitude toward it is still relatively free."[98] The idea that there are somehow degrees of individual freedom is left unexplained and unexplored in Frankl's theory.

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[97] Frankl, *Doctor and Soul,* 184-185.

[98] Ibid., 195.

While the above point has been noted in previous sections, what has yet to be explored is just how the logotherapist actually *engages* a client's freedom while simultaneously avoiding being a moralist and an intellectual but rather, being like an opthamologist, correcting one's vision. At least in the case of clinical neurosis, these theoretical maxims are not even discussed. Rather, the logotherapist is positively encouraged, in terms of method and attitude to engage in suggestion and persuasion when treating the clinical neurotic. What Frankl fails to acknowledge is that these methods and attitudes ultimately impact the goals of treatment and threaten the disciplinary viability of logotherapy. Logotherapy, in its practical applications of treating the clinical neurotics, at the very least, says nothing about "achieving meaning; encountering a realm of objective facts and values." In my view, by encouraging its practitioners to encourage radically subjective goals for their clients could actually violate what "remnants" of freedom a client has at his disposal.

Let us begin with the general description of the "unique" logotherapeutic methods that could be applied when treating the clinical neurotic. Of the choices available, namely paradoxical intention and dereflection, it is paradoxical intention that is recommended for treating the obsessional neurotic. By definition, "paradoxical intention means that the patient is encouraged to do, or wish to happen the very thing he fears."[99] The goal of this method is to allow a client to overcome anticipatory anxiety or what Frankl sometimes calls, "hyperintension."[100] What paradoxical

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[99] Frankl, *Will to Meaning,* 101.

[100] Ibid., 100.

intention attempts to overcome (and by implication *what* the focus of logotherapist *really* is in the confines of therapy) is described as follows:

> In order to understand the therapeutic efficiency of this technique we must consider the phenomenon called "anticipatory anxiety." By this I mean that the patient reacts to an event with a fearful expectation of its recurrence. However, fear tends to make happen precisely that which one fears, and so does anticipatory anxiety. Thus a vicious circle is established. A symptom evokes a phobia and the phobia provokes the symptom. The recurrence of the symptom then reinforces the phobia. The patient is caught in a cocoon. A feedback mechanism is established.
>
> How can we break up the vicious circle?.... to unhinge the circle, one must attack it on the *psychic* pole (emphasis mine) as well as on the organic pole. And the first is precisely the job done by paradoxical intention.[101]

There are two important conclusions that I want to draw from this quote. First, when using the technique of paradoxical intention, the focus of the logotherapist is no longer on the spiritual aspect of the person; but rather, on the psychic dimension of the individual.[102] Presumably, when effective, the client overcomes their psychic symptoms.[103] Having achieved a "proximate goal" of relief of psychological pain, the

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[101] Ibid., 102-3.

[102] Although not central to the discussion, an implication for clients who are said to need paradoxical intention is that the clients who come to a logotherapist may first and foremost (if not only and exclusively) be motivated to enter treatment for psychic suffering. Problems of meaning, or lack thereof, may not at the outset or ever be deemed a "legitimate" concern from the client's perspective.

[103] Frankl does describe an instance of when paradoxical intention was not successful. In *The Will to Meaning,* 109, he writes: "I had a man in my department, a guard in a museum who could not stay on his job because he suffered from deadly fears that someone would steal a painting. During a round I made with my staff, I tried paradoxical intention with him: `Tell yourself they stole a Rembrandt yesterday and today they will steal a Rembrandt and a Van Gogh.' He just stared at me and

ultimate work of logotherapy may then be said to begin, namely, the search for meaning. However, case after case of practical applications of logotherapy terminate with the goal of psychological symptom removal. What I am suggesting is that in cases of clinical neurosis, the proximate goal of a therapeutic technique seems to function as the end goal of therapy. It is unimportant to me how this final goal be described, be it in terms of happiness, relief of psychological pain, etc. What is important to note is that logotherapists appear to overstep their disciplinary boundaries or at the very least, are inconsistent with *what* they purport treat in the confines of therapy.

A second conclusion that was alluded to in earlier sections is Frankl's incoherent account of how the three different dimensions of the person causally interact. The mechanism of anticipatory anxiety presupposes a causal relationship between the physiological and psychological dimensions of the person. It is precisely at the psychic pole of the aforedescribed feedback mechanisms where logotherapists are recommended to intervene. Successful applications of paradoxical intention result in symptom removal/behavioral change. Yet, in the description of obsessional neurosis, Frankl states that it is the spiritual dimension where logotherapists were "obliged" to intervene; for it is this "attitude which has built up the basic constitutional disturbance." Mysteriously, the three aspects of the person "effect" each other and

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said, `But Herr Professor, that's against the law!' This man simply was too *feeble-minded* (emphasis added) to understand the meaning of paradoxical intention." Apparently, there are some selection criteria for clients who seek this kind of treatment. Intelligence is clearly one of them.

result in changes for the client. In the absence of a coherent causal account, it certainly appears as if logotherapists are magically capable of effecting these changes. In his recommendations to logotherapists, Frankl adds to this already confused account as follows:

> To say a thing is "psychogenic" is not equivalent to saying psychotherapy is indicated." Contrariwise, psychotherapy can be indicated even when it is not causal therapy. In other words, it can be the therapy that solves the problem, even when it is not specific therapy. The case of logotherapy is similar. Logotherapy can be an entirely suitable therapy even though it is neither causal nor specific.[104]

If this is the case, one must wonder, *what is the expertise of the logotherapist?*

A third conclusion follows from both the paradoxical intention quote and the description of obsessional neurosis. This implication concerns the language used to describe what it is that the logotherapist does when making a diagnosis and using logotherapy's techniques. In the description of obsessional neurosis, the reader is told that the logotherapist "...sets out to transform the neurotic's attitude" and that this attitude is "...subject to correction." In later passages on obsessional neurosis, it is said that the method for treating such a client may be by "re-education."[105] In addition, when addressing those aspects of obsessional neurosis that are impervious to change, Frankl instructs logotherapists as follows:

> That is, insofar as his illness does have some constitutional core, the patient *should learn to accept* the character structure

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[104] Frankl, *Doctor and Soul,* 281.

[105] Frankl, *Doctor and Soul,* 191.

> as fate, in order to avoid building up around the constitutional core additional psychogenic suffering. There is minimal constitutional basis which in fact cannot be influenced by psychotherapy. The patient *must learn to affirm* this minimum. The more *we train him to a glad acceptance of fate*, the more insignificant will be the residues of symptoms which are beyond help (emphasis added, mine).[106]

Again, I remind the reader to focus on the language in light of the preceding claims that the logotherapist is neither a moralist nor an intellectual, but rather like an opthamologist... For, certainly both the technique of paradoxical intention and other methods for treating the obsessional neurotic make it appear as if the logotherapist is engaged in a prescriptive task of some sort.[107] Nonetheless, with respect to the technique of paradoxical intention, Frankl devotes several passages in his books to denying this consequence. He says:

> Hans O. Gerz has pointed out: "One often hears the argument that it is 'suggestion' that gets the patients better. Some of my colleagues have attributed the results to my 'authoritarian' approach. Frankl has been accused of having made paradoxical intention successful because he is the great authority, the professor, and helps his patients with 'massive authoritative suggestion.' The fact is, however, that many other psychiatrists have been using Frankl's technique successfully. Cases have been reported as remaining symptom-free for even decades." Our patients often set out to use paradoxical intention with a strong conviction that it simply cannot work -- and yet, finally succeed. In brief they succeed not because of, but in spite of suggestion.

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[106] Ibid., 186-87.

[107] By way of clarification, I do not at this point, think it is possible to identify the exact normative project that logotherapists are be engaged in. Given the confusion surrounding the philosophical assumptions underlying this paradigm, a coherent account would seem to be rather impossible. In addition, to establish my claim, I need indicate that the therapist is minimally involved in some normative enterprise in order to demonstrate the inconsistency of Frankl's claims.

> This leads to another question -- namely, whether or not paradoxical intention belongs to the persuasive methods. As a matter of fact, paradoxical intention is the exact opposite of persuasion, since it is not suggested that the patient simply suppress his fears (by the rational conviction that they are groundless) but, rather that he overcome them by exaggerating them![108]

Despite these attempts at defense, I do not think Frankl's arguments have any legitimacy to them. To begin with, simply because psychiatrist's have reported success with the technique of paradoxical intention does not in any way refute the claim that the technique itself is suggestive. In short, these claims are wholly disparate and in no way even logically related.

Second, it is vacuous to claim that "paradoxical intention works in spite of suggestion" because, at some point, the patients must have heeded the suggestion to employ paradoxical intention even though, at first, they thought it could not work. Thus, paradoxical intention at some level has to be construed as suggestive. Frankl, himself may have later realized this. When defending this technique in *The Will to Meaning,* he says: "On the other hand, the remarkable results obtained by paradoxical intention cannot be explained *merely* in terms of suggestion" [emphasis added, mine][109]

Finally and with respect to Frankl's retort that paradoxical intention is not a persuasive technique, I believe that Frankl misunderstands the concept of persuasion itself. It seems to me that the very notion of "persuasion" says nothing about the *content* of what a person is encouraged to do, nor to think or believe. In other words,

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[108] Frankl, *Doctor and Soul,* 238.

[109] Frankl, *Doctor and Soul,* 110.

a person may randomly hold belief "x" and be persuaded by someone else to more forcefully adhere to that very same belief. Perhaps this is a semantic argument more than a substantive argument, but it seems to me that Frankl misunderstands the nature of persuasion. He suggests that paradoxical intention is not a persuasive technique because the person (is told!) to exaggerate the very symptoms he dislikes. This is simply no argument.

By way of conclusion, Frankl offers no convincing arguments to show that logotherapy as applied to clients who have a clinical neurosis is not suggestive nor persuasive. As such, and for the purposes of my thesis, if the door is opened to suggestion (in the sense of subtle/implicit prescriptions), then contrary to what Frankl claims, logotherapists are engaged quite unwittingly and misguidedly in a normative endeavor.

If this is the case, as I have tried to argue, then the goals of therapy with clients who suffer from clinical neurosis may be of one of two kinds: 1) if treatment terminates with the successful application of logotherapeutic techniques, then logotherapy may properly be said to afford an individual psychological relief *as a goal in itself.* Frankl would not want to admit this;[110] for happiness, defined as pleasure, is only a by-product of achieving meaning.[111] It is not clarified in Frankl's texts whether or not in this context, psychological relief is equivalent to happiness; yet, if this seems

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[110] For an argument of this point, see part one of this chapter.

[111] Frankl, *Will to Meaning,* 99-100, "When discussing the motivational theory of logotherapy I pointed out that the direct intention of pleasure defeats itself. The more an individual aims at pleasure, the more he misses the aim."

plausible, then one must acknowledge that logotherapists are not practicing consistent with their theory.

But, a second kind of goal could equally result for clients suffering from clinical neurosis, namely the therapist subtly coerces (through suggestion, persuasion, the very making of the diagnosis itself) the client to adopt his particular philosophical vision. Although, the theory of logotherapy claims that the authentic self must choose/act *by himself* with reference to objective being, in its very real applications, the appropriate balance between the client's self and being and self is suggested, etc. by the logotherapist. Such a goal is beautifully exemplified in the following passages. We shall first begin with a passage on the obsessional neurotic and then move to the general remedies for various clinical neuroses:

> Obsessional neurosis is not a mental disease, let alone a disease of "the spirit"; the position the person takes on the disease is independent of the disease. He remains free to change his attitude. It is imperative for the therapist to make use of this freedom. For obsessional neurosis "seduces" the obsessional neurotic to a particular philosophical position, namely that world-view of hundred-per-centness of which we have spoken above. ... Because of the overdeveloped awareness that accompanies the obsessional neurotic's acts of cognition or decision, he lacks that "fluent style" in which the healthy person lives, thinks, and acts."[112]

> To sum up, we may say that the normal person desires a half-way-secure world, whereas the neurotic seeks absolute security. The normal person desires to surrender himself to the one he loves -- while the sexual neurotic strives for orgasm, aims at that in itself, and thereby impairs his sexual potency. The normal person wishes to know a part of the world approximately -- while the obsessional neurotic wants a feeling of obviousness,

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[112] Frankl, *Doctor and Soul*, 191.

> aims at that and thereby finds himself being carried away on an endless moving belt. The normal person is ready to take existential responsibility for actual existence, while the neurotic with his obsessional scruples would like to have only the feeling (though an absolute one of a conscience at peace with itself. From the point of view of what men should desire, the obsessional neurotic wants too much; in terms of what men can accomplish, he wants too little.[113]

6b) The existential neurotics

A second class of clients is uniquely suited for treatment by logotherapists, namely those suffering from existential neurosis. Existential neurosis is characterized by "frustration of one's will to meaning,"[114] and as such, is a uniquely spiritual illness. One would expect the treatment of existential neurotics to be well-within the proper sphere of activity of logotherapy. The kinds of identifiable existential neurosis are: those suffering from the existential vacuum, unemployment disease, the Sunday-blues disease, the executive disease, etc.[115]

In almost all of Frankl's case studies, it is not at all clear that the clients are motivated to see a logotherapist because they are cognizant of the lack of meaning in their lives.[116] Typically, some other factors are the reasons for which clients seek

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[113] Ibid., 194.

[114] Ibid., xvii.

[115] Frankl, *Psychotherapy and Existentialism*, 122-4.

[116] For an example, see Frankl, *Doctor and Soul,* 121, 124. When describing several cases of existential neurotics, Frankl attributes their reason for visiting a logotherapist to a feeling of despair, sometimes accompanied by the desire to commit suicide.

treatment. At least in these cases, it is incumbent upon the logotherapist to inform clients -- or, to lead them to interpret their own suffering -- in existential terms and hence, as a lack of meaning.

While paradoxical intention and dereflection are specific logotherapeutic techniques employed with those suffering from clinical neurosis; no specific techniques are advocated for the treatment of existential neurotics. However, Frankl is insistent that the personal values of logotherapists not impact a client's search for meaning -- the purported goal of treatment for the existential neurotic. He says:

> In this sense existential analysis also remains non-committal on the question of "to what" a person should feel responsible -- whether to his God or his conscience or his society or whatever higher power. And existential analysis equally forbears to say what a person should feel responsible for -- for the realization of which values, for the fulfillment of which personal tasks, for which particular meaning to life. On the contrary, the task of existential analysis consists precisely in bringing the individual to the point where he can of his own accord discern his own proper tasks, out of the consciousness of his own responsibility, and can find the clear, no longer indeterminate, unique and singular meaning of his own life.[117]

> Continuation of the treatment... so that it intrudes into the personal sphere of particular decisions, must be termed impermissible. The physician should never be allowed to take over the patient's responsibility to be shifted to himself; he must never anticipate decisions or impose them on his patient. His job is to make it possible for the patient to reach decisions; he must endow the patient with the capacity for deciding.[118]

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[117] Ibid., 275-6.

[118] Ibid., 276-7.

Within clinical practice, it is difficult to understand how a logotherapist actually engages a client's sense of conscience and responsibility without "imposing," on some level, his own values on the client. Examining actual descriptions of clinical encounters consistently leads one to the conclusion that in the endeavor for clients to find their own meaning, the logotherapist's personal values are indeed, either covertly or overtly suggested to the client. If this is the case, then logotherapists must admit that a search for meaning is never purely a client's own, individual endeavor; but rather, their personal search is strongly guided by the logotherapist himself. When one adds to this consideration that theoretically logotherapists unwittingly are told to believe that their own values are not operative in the context of logotherapy, this exponentially increases the possibility that uncritically analyzed personal values may impact the a client's search for meaning.. The following illustrates how this might be said to occur in practice. Moreover, I challenge to the reader to consider whether the client could really be said to have *benefitted* from treatment: .

> A patient was sent to a psychiatrist because she was troubled by an intense fear of syphilis. It developed that she was suffering from a general neurotic hypochondria. She misinterpreted neuralgic pains as signs of luetic infection. ... In this particular case the patient did not have these sexual guilts. It was true that she had been the victim of rape, but she was sensible enough to have no guilt feelings about that isolated sexual experience. Her guilt feeling had reference to another aspect of the matter entirely: that she had not told her husband about the incident. Here she was again being sensible; she deeply loved her husband and had wanted to spare his feelings, since she knew him to be a distinctly suspicious person. Her confession compulsion was not a symptom at all. It therefore was not susceptible to the ordinary interpretations of psychotherapy; what was required was the logotherapeutic methods of matter-of-fact

> discussions, of taking the moral issues at face value. In fact, the confession compulsion promptly vanished the moment the patient realized that in the concrete case her continued silence was an obligation she owed to her love. She perceived that there was no need to make any confession since only guilt can be confessed, and she felt herself to be free of any real guilt. Moreover -- here we have an analogy to a case mentioned in another connection -- she would only have conveyed quite the wrong impression to her suspicious husband and would have been deceiving him with the truth. This patient, then, could only be reassured when her conscience was reassured. And her conscience was not troubled over the sexual incident, but only in regard to the dubious moral obligation to confess.[119]

This example is a clear illustration of how and where a logotherapist's personal values actually do impact the goal of treatment. Much more than merely allowing a patient to clarify her particular meaning, the logotherapist deems her understanding of her rape and her decision not to tell her husband about it as "sensible!" More strongly, it is said that the client had an obligation to withhold this information from her husband so that he may not suffer. Frankl is quite right in suggesting that this is a case involving moral issues; however, it certainly seems as if the "decision" that was made by the client at the end of treatment was strongly guided by the logotherapist. Contrary to facilitating her contact with an objective realm of values and/or encouraging her to engage in value clarification, *it was the logotherapist* who succinctly judged her decisions to be "sensible."

Some might suggest that such cases are not detailed enough to make sweeping claims. Let me be clear in saying that it is not incumbent upon this analysis to show how in *all* cases suggestion is operative; but only, that at least in some cases,

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[119] Frankl, *Doctor and Soul,* 271-2.

suggestion is present. If this is the case, then indeed, logotherapists are acting in the capacity of a moral advisor and/or intellectual. Additionally, they are quite simply not practicing in accord with the theory of logotherapy. But most importantly, I leave it to the reader to judge whether or not clients are really led to discover their own meaning in this form of therapy.

7) Conclusion

Had Viktor Frankl written *Man's Search for Meaning*, solely to discuss the importance that "meaning" has in human life, I doubt that I would have devoted the preceding pages to an analysis of that *inspirational* message. Indeed, Frankl's tales of the concentration camps and his concomitant message that those who survived were those who had found meaning are extraordinary. As such, they deserve to be read by those who want to consider how Frankl's thoughts may enrich their own walk through life.

However, Frankl purported to do more than offer life lessons. As was noted in the introduction, he developed this discipline of logotherapy to serve as a corrective to existential analysis. *It was as a paradigm of psychotherapy*, that I investigated logotherapy. Unlike any other paradigm of psychotherapy assessed in this dissertation and from the very beginning, I have demonstrated that logotherapy must be viewed as both inconsistent and incoherent. In other words, the fact that logotherapy's purpose was unclear -- sometimes viewed as a "supplement" and at other times a "substitute

for psychotherapy" -- led us down a long path of demonstrating the inconsistent meanings of its assumptions and as a result, of its applications.

This analysis then, has important implications for those who write about the theory and purport to engage in the practice of logotherapy. Today, there is an independent journal called: *The International Forum for Logotherapy.* Contributors clarify the theory and report on its applications. In a recent article, entitled: "The Dynamic of Meaning," Jana Preble, a "diplomate of logotherapy" and associate professor of applied psychology cites three case examples of those successfully treated by logotherapy." After claiming that it was discovering a third grade boy's "world of meaning" that ultimately was the *the* key to success for teaching him how to read, Preble unabashedly claims:

> Logotherapy is consistent as a philosophy and a viable therapy. There is no need for manipulation, no forcing a client to fit a treatment, or a treatment to fit a client. All that is occasionally required is a shift in perception, a new way of seeing that expands persons rather than limits them.[120]

As I have argued, considerations as to how, why and who is truly responsible for this "expansion" are extraordinarily ambiguous in logotherapy. For that reason, I find Preble's assurance of the consistency of logotherapy quite discomfiting. As I have attempted to demonstrate in this chapter, clients who are treated in this form of therapy may in the end say that they have found "meaning" -- but its nature, reality,

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[120] Jana Preble. "The Dynamic of Meaning," *International Forum for Logotherapy,* vol. 14, no. 2 (Fall, 1991): 98.

and whether or not they, as free and responsible individuals have authentically chosen it is all but clear.

CHAPTER FOUR

CONSIDERATION OF THE STATE OF CONTEMPORARY PSYCHOTHERAPY: AN ANALYSIS OF SHORT-TERM DYNAMIC PSYCHOTHERAPY

The three paradigms of psychotherapy analyzed in this dissertation no longer exclusively characterize contemporary theory and practice. As stated in the Introduction, the paradigms were selected for the following reasons: 1) historical significance and 2) an extensive literature that attempts to articulate the nature of the school of thought. These two factors made it possible to demonstrate competing metaphysical and normative commitments. Although many therapists today still adhere to aspects of these schools of thought, very few would define their practice by any one theoretical orientation.[1] Rather, there is growing evidence that psychotherapists are rejecting the limitations of particular schools of thought in favor of an eclectic orientation. [2,3] If this *is* indeed the case, one might claim that my thesis

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[1] Council for the National Register of Health Service Providers, *National Register*, I-13: "Each Registrant may identify a primary and secondary orientation, neither, or only a primary or theoretical orientation. These choices were based upon the descriptions psychologists use and are by necessity limited. As a result, the orientations listed may not be entirely reflective of a Registrant's practice. The choices are as follows: Behavioral, Cognitive/Cognitive Behavioral, Existential/ Humanistic, Interpersonal, Psychodynamic, Social Learning Systems."

[2] Sol L. Garfield. *Psychotherapy: An Eclectic-Integrative Approach* (New York: John Wiley & Sons, 1995), 3: "While such popular orientation as psychoanalysis and its derivatives and behavior therapy have had a marked influence

is only of historical interest insofar as it describes the practice of psychotherapy of a day gone by. Given the trend of eclecticism, theoretical analyses of paradigm-specific practice could only be a caricature of actual practice. By implication, any attempt to distill the normative assumptions present in the practice of psychotherapy would be unrealistic.

This final chapter is offered as a response to such objections. In part, I will explain why the current eclectic orientation in psychotherapy in no way renders my thesis obsolete. Values are still present in the theory and practice of contemporary psychotherapy. Eclecticism can only be said to make the project itself more complicated -- both in terms of identifying "possible" paradigms and investigating normative assumptions as they may appear in practice.[4] As a result of this

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on the developments within the field, a majority of practitioners do not appear to follow any particular school exclusively, or to limit themselves to the theories and procedures of just one theoretical orientation. For example, in a 1970's survey of 855 clinical psychologists, over half of them indicated that they were eclectics (Garfield & Kurtz, 1976) Since that time, a number of additional surveys have been conducted, and although the percentage of individuals identifying themselves as eclectics has varied from study to study, the eclectic orientation has generally been the most popular. In a recent study of clinical psychologists, psychiatrists, social workers and marriage and family therapists, 68% of the sample of 423 individuals indicated an eclectic preference (Jensen, Bergin & Greaves, 1990).

[3] As stated by Dr. Lowy in *Basic Principles and Techniques in Short-Term Dynamic Psychotherapy* by Habib Davanloo. 1st ed. (New Jersey: J. Aronson, 1994), 93: "What is remarkable about this meeting is the absence of a school of thought. It has been noted a number of times that schools are for minnows and fish and not for scientists, and it is really quite refreshing to have an absence of `this school versus that school.'"

[4] It is important to acknowledge at this point two possible reactions to my thesis: 1) Some therapists might claim that they adopt their ideas from so many

"complication" and unlike previous chapters, a brief foreward addressing the presence of paradigms in contemporary psychotherapy will be necessary. Exploring this issue will make it apparent as to why my thesis must be tempered. Given the nature of the paradigm I intend to investigate, namely Short-Term Dynamic Psychotherapy,[5] and the manner in which it developed, I am only able to demonstrate where certain theoretical commitments might allow for a therapist's personal values to enter into the practice of therapy.

Eclecticism and the problem of paradigm identification

Since the 1960's, there has been a rapid growth in the number of new forms and techniques of psychotherapy. Recent estimates suggest that there are 450+ approaches to psychotherapy. This recent statistic viewed in light of the following

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paradigms that the very identification of a coherent normative project would be impossible. In this case, I would urge therapists to engage in critical reflection so as to decipher exactly which assumptions they adopt from which schools of thought. It may be the case that two assumptions are contradictory or imply contradictory normative claims. Both could negatively impact the client. 2) Some therapists might reject practicing from within any paradigm whatsoever (non-paradigmatic practice). Two responses are applicable: a) Values are still likely to enter into the practice of psychotherapy, but they are non-paradigmatic values (i.e. the therapist's personal values, religious values, etc.) or b) One could question the "legitimacy" of practicing psychotherapy in this way. As stated by Sol L. Garfield, in *The Practice of Brief Psychotherapy.* (Elmsford, NY: Pergamon, 1989), 19: "Needless to say, if this rate of increase continues [the growth of schools of thought], at some point we will have a different form of psychotherapy for every person in the United States. This manifestation of the free enterprise system, perhaps, may epitomize true democracy, but whether it is an ideal situation for psychotherapy is another matter."

[5] In this chapter, "Short-Term Dynamic Psychotherapy" is abbreviated as STDT. I will use STD in front of the term "therapists."

quote seems to indicate that the sheer number of forms of therapy virtually doubles every ten years. As Garfield says:

> "By the mid-1960's, I had accumulated over 60 different approaches to psychotherapy... In the 1970's, a report from the National Institute of Mental Health made reference to the existence of over 130 different forms of psychotherapy (Report of the Research Task Force of the National Institute of Mental Health, 1975). And, this burst of unusual creative efforts in psychotherapy has continued. Just five years later, Herink (1980) published *The Psychotherapy Handbook: The A to Z Guide to more than 250 Therapies in Use Today.* A few years later, Kazdin (1986) made reference to the existence of over 400 therapeutic techniques.[6]

Ironically, psychotherapists have greeted this increasing diversity with a curious mixture of enthusiasm and concern. While many therapists welcome the creative developments and new techniques for treating clients,[7] others appear to be concerned that the diversity has caused a kind of disciplinary confusion for the field of psychotherapy.[8, 9]

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[6] Garfield, *Psychotherapy: An Eclectic-Integrative Approach,"* 1.

[7] Jeremy Holmes and Richard Lindley. *The Values of Psychotherapy.* (Oxford: Oxford University Press, 1989), 9: "The convergence of the psychotherapies while retaining their separate identities is, in our view, one of the positive features of contemporary psychotherapy. The recent development of cognitive behavioral therapies, for example, means that behavior therapists now recognize the inner world of their patients, and are beginning to build bridges with analytic therapies."

[8] Garfield, *Psychotherapy: An Eclectic-Integrative Approach,* 2: "Such diversity is confusing to people entering the field. It is equally confusing for individuals outside the field. There can be too much of a good thing. This diversity raises some basic and intriguing questions concerning what is really important in psychotherapy. In other words, what are the variables or processes that lead to positive change in psychotherapy? Does one school of thought have a more correct view of these fundamental processes, or are all approaches either viewing different parts of the elephant or characterizing similar phenomena in different ways?"

The overall effect that the proliferation of forms of therapy might be said to have on clients and for the discipline in general is not the central concern of this chapter. Rather, the question that concerns me is to what extent it is possible (or not) to identify paradigms amidst the many new "forms" of psychotherapy. One wonders, for example, if these 450 forms of therapy really share all or even most of the features of the three, historical paradigms analyzed at the beginning of this dissertation. That is to say, one wonders if they are defined by the fact that they were founded by a specific individual; advocate specific notions of reality and mental illness; and/or have an identifiable community of practitioners. Unfortunately, scholars writing on this topic have been notoriously vague regarding what constitutes a new "form" of therapy.[10, 11] Concerns of this kind, together with the sheer number of developments in

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[9] See Light, Donald. *Becoming Psychiatrists: The Professional Transformation of Self,* 1st ed., (New York: Norton, 1980), 290. Light makes a distinction between "strong and weak paradigm development" within medicine. By paradigm development, he means: "the degree to which there is consensus among practitioners about the theory or paradigm underlying their work." He says: "The studies of residents in orthopedic surgery and psychiatry are particularly useful for looking at awareness of uncertainties because the strength, and to a lesser degree, the development of their paradigms contrast so sharply. Psychiatry is widely regarded as having weak and competing paradigms to guide its diagnosis, treatment and research; while orthopedic surgery has a strong paradigm with competing derivations," 290.

[10] Psychotherapists themselves writing on this topic have neither been very careful nor consistent about the language used to describe these forms of therapy -- whether they be schools of thought, paradigms, new techniques, etc. One of the most curious uses of language occurs in Holmes and Lindley, *Values,* 3. They say: "Psychotherapy is enormously diverse. The *Psychotherapy Handbook* lists over 300 types of therapy ranging from Active Analytic to Zaraleya Psychoenergetic Technique. Most therapists follow *a particular school or tendency*, (emphasis added) and the authors are no exceptions."

[11] Garfield, *Psychotherapy: An Eclectic-Integrative Approach,* 1-2.

psychotherapy, make the task of paradigm identification difficult at best.

Two additional phenomenon that add to this difficulty deserve to be mentioned: namely, the resurgence of the medical model in treating mental illness (the rise of psychotropic drugs) and a growing number of therapists that establish what is loosely defined as the "helping professions." With respect to the first issue, I believe that the medical model does, in some sense, pose a problem for the present analysis. An increasing number of scientific studies suggest that a combined use of psychotherapy and psychotropic medication in the treatment of mental illness constitutes the best form of treatment.[12] The increasing popularity of combining neuroscientific and psychotherapeutic remedies further erodes attempts to identify "pure" normative projects in contemporary psychotherapy.

Finally, the sheer growth in the variety and numbers of people in the "helping professions" also contributes to the problem of identification. It is interesting to note that Freud, Sullivan and Frankl shared several features in common: all were medical doctors, all practiced psychotherapy at a time when the discipline was still young and relatively small[13] and all adhered to psychoanalysis at some point in their lives.

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[12] For an example see Lester Luborsky, Paul Crits-Christoph and A. Thomas McLellan. "Do Therapists Vary Much in Their Success? Findings from Four Outcome Studies." *American Journal of Orthopsychiatry,* Vol. 56 (October 1986): 501-12.

[13] *Statistical Abstract of the United States,* 115th Ed., (Washington, D.C.: U.S. Department of Commerce: Economics & Statistics Administration, Bureau of Census, 1995), 411: Statistics comparing the years of 1983 and 1984 verify the staggering growth in terms of numbers and kinds of individuals involved in this profession. (Data

Today, the field of psychotherapy has extended beyond the realm of medical practice and includes social workers, marriage and family therapists, school psychologists, pastoral counselors, occupational therapists, etc. In terms of differences in licensing, educational background and variable contexts under which these practitioners claim to treat the mentally ill, the contemporary scene of psychotherapy has grown and altered considerably.

In light of these three factors, some stipulations need to be provided at the outset of this chapter. First, when I refer to a paradigm of psychotherapy, I will only be referring to it in its "pure" form. That is to say, the paradigm discussed in this chapter will be reviewed on its own terms and without reference to how drugs might interfere with or change its ideology. Fusing two distinct schools of treating mental illness in practice carries with it the possibility of substantively affecting the underlying assumptions implicit in a school of thought. For these reasons, neither a pure medical approach nor a combined neuroscientific and psychotherapy approach shall be discussed in what follows..

Second, I have chosen to confine my analysis to a relatively new "form" of therapy which today functions as a paradigm of sorts. Short-Term Dynamic

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per 1000 individuals employed):

	1983	1994
Therapists:	247	430
Counselors:	184	237
Psychologists:	135	280
Social Workers:	407	667

Psychotherapy is arguably a suitable focus for this chapter because it shares many important features with the historical paradigms assessed earlier. Short Term Dynamic Therapy (STDT) seems to meet many of the criterion of Kuhn's conception of "paradigms." For example, STDT at least has a history of some twenty or more years in which it was developed and gained acceptance in the psychotherapeutic community. One sign of evidence for such acceptance is that STDT has at least one academic journal developed to researching and further articulating the paradigm.[14]

There are some features, however, of STDT which impede its analysis as a paradigm. As the analysis will show, the manner in which Short-Term Dynamic Therapy developed as a paradigm of sorts is relatively complex. The number of thinkers to whom proponents owe their allegiance are various. In addition, and in a different spirit from the historically based paradigms assessed in the first three chapters of this dissertation, contemporary modes of psychotherapy tend to strike one as consisting of a potpourri of techniques. This should hardly be surprising. Typically, as a discipline develops, new paradigms develop in reaction to and yet as an outgrowth, often times, of previous modes of thought. When and where metaphysical assumptions are operative, very rarely is there a theoretical explanation -- that is, notably of the nature of the self, worldview, and even of mental illness. Nonetheless, where at least Freud, Frankl and Sullivan attempted to explain the assumptions in their theories, it seems as if contemporary paradigms tend to ignore

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[14] See, *The International Journal of Short-Term Psychotherapy* (New York: John Wiley & Sons, Ltd.), vol. 1 (1986--).

addressing these issues altogether.[15]

Finally, my analysis of this paradigm will be limited to the approach taken and the explanations provided by either clinical psychologists or psychiatrists. While social workers and counselors may purport to adopt a psychodynamic orientation, other factors indicate that their operative normative assumptions and goals may be decidedly different from psychologists and psychiatrists. These factors are: the contexts within which they do their work, their respective clients and the education they have received. Additionally, it should be noted that social workers and counselors have not been the creators of these paradigms themselves, but rather, clinical psychologists and psychiatrists have largely been responsible for their articulation in the past and at present.

There are a variety of possible methods for exploring my thesis in this chapter in light of these difficulties.[16] In the following analyses of STDT, I will attempt to

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[15] I suspect that one reason for this is because these approaches are seen as historical developments of previous theories. Perhaps, then, there is a sense that these issues have been adequately addressed by previous theorists. A second reason may be due the fact that contemporary theories seem to place much more emphasis on techniques, goals of therapy, etc. at the expense of "factual notions" (and hence normative notions attached to these). Whatever the case may be, the choice of the appropriate methodology for exploring the thesis of this dissertation is undoubtedly made more complex in virtue of these two issues: 1) the "eclectic" feel of the theories themselves along with 2) an apparent disregard for the metaphysical assumptions underlying the historical theories to which they appeal.

[16] Given the above considerations, one possible mode of exploring STDT would be to distill this paradigm to its ultimate origins. For example, STDT has its theoretical roots in the dynamic theories of Freud, Klein, Rank, and more recently French & Alexander, etc. If a reductionistic account could be achieved, then, one could argue that STDT is simply a briefer version of traditional psychoanalytic theories and as a result, shares most, or even all, of its normative assumptions.

distill the general features of the paradigm itself and attempt to crystallize its unique and/or foundational tenets. By such a distillation of these ideas in their own right, perhaps one will be able to judge if in fact from these features alone (the features that are most discussed), discernable metaphysical features can be noted or not. If this exists as a possibility, then obviously one will be able to move on to the normative assumptions contained therein. Once these two moves have been accomplished, connections which exist between the contemporary paradigm and those that have historical ties will be noted. The advantage of this methodology is that one can still preserve the uniqueness of the contemporary paradigms (and thereby avoid reductionism) as well as highlight what is novel about STDT. In addition, though, if indeed points of "real" contact exist between the metaphysical assumptions and historical paradigms, this can duly be noted.

The origins of short-term dynamic therapy

In the book, *Basic Principles and Techniques of Short-Term Dynamic Therapy,*

Despite its appeal, this methodology suffers from a major flaw. Even though the proponents of this theory acknowledge their indebtedness to past thinkers, and paradigms, they are often eager to emphasize the novelty of their school of thought and hence, would seem to be unwilling to acknowledge a strict reduction to foundational paradigms. By way of an example, STDT's recommend that therapists take an active, even confrontational, approach towards their clients in order to have successful therapeutic outcomes. This stands in marked contrast to Freud's recommendation to analysts. More than representing a mere variance in their approach, STD therapists claim to be doing something new by theoretically articulating the role of the therapist. This novelty, by their own admission, could not possibly admit of a reduction to the metaphysical, and as a consequence, to the normative assumptions involved. In the end, this approach is not choiceworthy.

H. Davanloo and J. Marmor provide forewords to the proceedings of the First and Second International Symposiums on Short-Term Psychotherapy held in 1975-76. Both claim that the ultimate origin of the paradigm hearkens back to Freud's psychoanalysis (insofar as this is an instance of dynamic therapy), and also to the work of Alexander and French in the 1940's.[17]

The writings of Alexander and French serve as an interesting bridge between Freud's psychoanalysis and the development of STDT. As Marmor tells us, Alexander and French began to experiment and modify standard Freudian psychoanalytic principles, particularly as they concern the length, frequency and regularity of intervals that the client was seen. In addition, they began to experiment with the concept of transference with the hope that a more active role of the therapist could produce faster results. Their seminal work, *Psychoanalytic Therapy* (1946) was greeted negatively by the analytic community. Although Marmor does not tell us why this was the case, presumably it had to do with the very idea of modifying an already accepted scientific paradigm of therapy namely, Freud's psychoanalysis.[18]

In the late 1950's and early 1960's, at least three psychiatrists (H. Davanloo, D. Malan and P.E. Sifneos) continued the experiments with the techniques of traditional psychoanalytic therapy. The impetus behind their research was largely a practical concern, as Sifneos claims:

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[17] Franz Alexander and T.M. French. *Psychoanalytic Therapy: Principles and Application.* (Lincoln: University of Nebraska Press), 1946.

[18] Davanloo, *Basic Principles, 2.*

> (STDT) was developed nearly forty years ago in order to meet the demand for psychotherapeutic help which far exceeded the availability of trained therapists, and to counteract the prevailing -- and I feel absurd -- idea that long-term psychotherapy was the only way to change human attitudes and behaviors.[19]

An economic explanation for the paradigms development can be noted here: supply of therapists and the prevailing demand for therapy created the need for shorter forms of psychotherapy that nonetheless could yield significant and long-lasting improvements for the client. Some might be tempted to claim that the paradigm itself, then, only differs from psychoanalysis in virtue of its limited duration. Again while the brevity of treatment was a foundational concern to the originators of STDT, substantive differences in terms of technique, role of the therapist, selection criteria of clients were explored in each of their forms of treatment. In the early 1970's, the American psychiatrists, Davanloo and Sifneos, met and discussed their findings. A little later, they became acquainted with the English psychiatrist, D. Malan, who had for some years been exploring briefer forms of psychotherapy. Motivated by a similar concern, yet pursuing their work independently of each other, they agreed to meet in the mid-1970's in order to discuss their work.

This, in brief, is the history of STDT. In what follows, we will explore the theoretical commitments of STDT with the hope of identifying where, at the very

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[19] Peter E Sifneos. *Short-Term Anxiety Provoking Psychotherapy: A Treatment Manual,* (New York: Basic Books, 1992), x. See also: "The Current Status of Individual Short-Term Dynamic Psychotherapy and its Future: An Overview," *American Journal of Psychotherapy,* vol. 38, no. 4, (October, 1984): 472.

least, normative assumptions may appear. This will be done keeping in mind the historical ties that STDT has to Freud's psychoanalysis. For if it is the case that STDT is simply a briefer version of psychoanalysis, then it could be the case that many of its normative assumptions are the same as those identified in Chapter 1.

The logic of short-term dynamic therapy

> In practice, it is true, there is nothing to be said against a psychotherapist combining a certain amount of analysis with some suggestive influence in order to achieve a perceptible result in a shorter time -- as is necessary for instance in institutions. But one has a right to insist that he himself should be in no doubt about what he is doing and should know that his method is not that of true psychoanalysis.[20]

> 567. But, after all, the game is supposed to be defined by the rules! So, if a rule of the game prescribes that the kings are to be used for drawing lots before a game of chess, then that is an essential part of the game. What objection might one make to this? That one does not see the point of the prescription. Perhaps as one wouldn't see the point either of a rule by which each piece had to be turned round three times before one moved it. If we found this rule in a board-game we should be surprised and should speculate about the purpose of the rule. ("Was this prescription meant to prevent one from moving without due consideration?")[21]

As noted in the previous section, STDT appeared roughly at the same time albeit by three key persons working independently of each other. Because of this, by

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[20] Freud, *SE* 12: 118.

[21] Ludwig Wittgenstein. *Philosophical Investigations*, trans. G.E.M. Anscombe, (Oxford: Blackwell Publishers, 1963), 150-1.

the time First International Conference on STDT was held, what I would like to call "private language games"[23] were already rather well-developed. Sifneos, working at the Beth Israel Medical Center, coined his version of psychotherapy as "Short-Term Anxiety-Provoking Psychotherapy (STAPP)." By contrast, Davanloo developed what he called, "Broad-Focused Short-Term Dynamic Psychotherapy (BFSTDP)." The individual theoretical differences along with different research methods and outcomes prompted the desire to search for common ground in the mid-1970's.[24]

In spite of the individualized manner in which STDT emerged, I will attempt to explore the general logic behind versions of STDT in this section. This is possible because several structures are broadly recognized in STDT. As I will argue, these structures appear to function like the "rules' of a game. Each one of the categories discussed below is logically, even necessarily linked to another. This structure, in some sense, indicates how this form of psychotherapy is to be practiced. Yet, despite the apparent formal nature of the rules, as we work through each category it will

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[23] I make this point about there being "private language games" existing in the realm of STDT to highlight yet again, a difficulty noted at the outset of this chapter. As I suggested earlier, focusing a discussion of major paradigms in contemporary psychotherapy is a problematic task. One wonders if the differences, let us say, between Sifneos' version of STAPP and Davanloo's BFSTD are of such qualitative import so that they do in fact constitute different paradigms altogether. So, another stipulation is in order. I will treat STDT as a paradigm unto itself and yet, when focusing in on, a feature that is unique or more highly noted in one theory as opposed to another, I will alert the reader to this fact.

[24] Walter V. Flegenheimer. *Techniques of Brief Psychotherapy.* (New York: Jason Aronson, 1982): Other versions of STDT identified are: Intensive Brief Therapy of David Huntingford Malan; Time-Limited Psychotherapy of Mann; Eclectic-Integrated Therapy of Wolberg, etc.

become increasingly apparent that the rules (and the overall game) operate according to the individual interpretations of the therapist. Thus, in my view, Short-Term Dynamic Therapy is a form of therapy that appears to have built-in warrants for its practitioners to rely on personal values.

Selection criteria of clients

Unlike any other contemporary paradigm, STDT theorists are quite specific in defining the kind of patient that qualifies for treatment. As we will soon see, this highly specific and limited number of individuals largely sets the pace for how this kind of treatment works.

In his book, *Short-Term Anxiety Provoking Psychotherapy*, Sifneos offers the most comprehensive list of selection criteria for clients. In brief, clients must be: intelligent and/or psychologically-minded; have exhibited meaningful relationships in the past; present with a focused problem; and relate flexibly to the examiner, with positive and negative feelings exhibited appropriately.[25] Each criterion is significant because it determines not only the substance of the following categories/rules but also, the success or failure of the practical application of the paradigm.

To begin exploration of some of these features, at times, there is a tendency to subsume them under a general heading that clients must exhibit a "strength of

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[25] Criteria distilled from Peter E. Sifneos. *Short-Term Anxiety Provoking Therapy: A Treatment Manual* (New York: Basic Books, 1992), 19. See also: Davanloo, *Basic Principles,* 9-34.

character."[26] Whether or not these features alone are constitutive of character or not, the operative word in this phrase does indeed seem to be "strength." Clients who are admitted into STDT must possess both cognitive and emotional resilience. If strength of this nature is a prerequisite for "treatment" of a "mental illness," of course, one naturally wonders what mental illness constitutes on these terms. This of course, will be explored in the next section. For now, let the following remarks suffice as to the criteria of selection of patients.

In STDT, persons who are intelligent are those "with a highly developed capacity to deal with complicated concepts."[27] According to Malan, the most important way of exploring a client's intelligence is to see how the client responds to "tentative confrontations and classifications."[28] Interestingly, the degree to which clients use sophisticated language does not indicate their level of intelligence for clients, it is said, may not fully understand the meaning of their words. Appeals to other forms of testing intelligence, (i.e. IQ tests, work status, level of education, etc.) are not mentioned by these theorists. The underlying and obvious conclusion to be drawn is that intelligence of a client upon entry into STDT is solely a function of the extent to which she can absorb the clarifications/interpretations offered by her therapist. If this is how intelligence is construed in practice, this may indeed be an area where normative judgements enter into STDT. In the absence of objective

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[26] Sifneos, *Short-Term,* 20.

[27] Ibid., 36.

[28] David Malan. *The Frontier of Brief Psychotherapy*, (New York: Plenum Press, 1976), 36.

measures for determining intelligence, the ultimate standard by which competence is judged is by the individual therapist.

In addition, a client's emotional fortitude also constitutes part of the generic term, "strength of character." "Psychological mindedness" falls under this category. By and large this consists of a) one's capacity at introspection and b) ability to withstand the various techniques of STDT.[29] This latter category consists of: confrontation, clarification, exploration, manipulation, abreaction, interpretation and anxiety-provoking techniques.[30] Clients who are not capable of withstanding these techniques are not deemed suitable candidates for STDT. As Malan notes in his recent book, *Individual Psychotherapy & the Science of Psychodynamics:*

> There are two classes of patients with whom purely dynamic psychotherapy tends to be ineffective: 1) those who are very fragile or badly damaged emotionally; and 2) those who either start with massive resistance or else develop subtle forms of impenetrable resistance during their therapy.[31]

As point 1) of the above quote indicates, strength to withstand emotionally charged techniques delimits STDT candidates; but also, I would urge one to pay specific attention to issue 2) of the above quote. It is not an arbitrary fact that those clients who present with what is deemed as "massive resistance" are also rejected -- resistance perhaps to acknowledging/giving credence to a therapist's interpretation.

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[29] Davanloo, *Basic Principles,* 17.

[30] Ibid.

[31] D. Huntingford Malan, *Individual Psychotherapy and the Science of Psychodynamics*, 2nd ed., (Boston: Butterworth-Heinemann, 1995), 273.

A third feature, namely, that persons have had a meaningful human relationship during childhood is the most curious selection criterion. Sifneos offers the most comprehensive explanation. He says:

> Making a sacrifice for another person at the expense of one's own pleasure is evidence of altruism. A child's demonstration of altruism at an early age denotes a capacity to interact flexibly with another person in a give-and-take way. Such a relationship is "meaningful." Why should one go about investigating so thoroughly the existence of one meaningful relationship in early childhood? Altruism and the capability of expressing feelings for another person in a give-and-take way are evidence that the patient reached a level of psychological maturity at an early age. Such an individual is not likely to become psychotic or develop a borderline or narcissistic personality later in life. In this sense the second criterion attempts to rule out these more serious conditions and gives the evaluator an opportunity to pursue an investigation of the patient's character strengths and suitability for STAPP.[32]

This passage has important implications not only for the logic of STDT but also, as I will argue, for the normative assumptions that this kind of therapy might involve in practice. With respect to the logic, it will be shown that the criterion that one has had a meaningful relationship directly bears upon the second rule of the game of STDT, namely diagnosis. In principle, neither psychotic, narcissistic, or borderline personality disorders are treatable illnesses within the confines of STDT. More than a way of delimiting treatable categories of mental illness, though, altruism greatly colors the kind of therapeutic relationship that is considered valuable in STDT. For, depending upon how the therapist interprets the meaning of "altruism" and "give-and-take

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[32] Sifneos, *Short-Term*, 23-24.

interaction" with others, the extent to which there exists an asymmetrical balance of power between the client and the therapist as well as the degree to which the personal values of the therapist may impact the practice of STDT will be indicated.

Let us take a closer look at what Sifneos might *mean* by the terms, "altruism" and "give-and-take interaction with others." Sifneos seems to understand the term "altruism" as the ability of one to make sacrifices for another. I would venture to say that this is a rather extreme way of defining the term --- the term "sacrifice" implying that one might do something for others *at the expense of their own interests and/or their own well-being.* Nonetheless, even if we were to understand "altruism" in a less extreme sense, (i.e. altruism as opposed to egoism as typically distinguished in ethics), at the very least, altruism implies that one has "other-centered" interests in contrast to merely attempting to satisfy one's own self-interest. Now, if this latter definition were to be what Sifneos means by the term, "altruism," one might still argue that this usage of altruism implies something radically different than a "give-and-take interaction" with others.

A simple example may easily illustrate my point: Mother Teresa's work with the poor in Calcutta is typically called altruistic -- her self-less and untiring labor for the sake of others has been well established. Now, while it may be the case that Mother Teresa might claim that she receives more personal gratification, etc. as a by-product of her work, it is highly unlikely that one would claim she is really engaged in a type of "give-and-take relationship" with those whom she helps. The latter clearly implies an egalitarian relationship, one based on the expectation that reciprocal

interests and needs will be satisfied. In sum, the term, altruism could be said to have at least three different meanings: sacrifice, taking into account the interests of others, and "give and take interactions."

Now, to some, it may seem as if I am belaboring a trite issue. However, I explained the various meanings of this term because I believe that the criteria of having had at least one "meaningful" childhood relationship has far more importance than simply delimiting those diagnoses that are non-treatable in STDT, namely: narcissism, borderline and psychotic disorders. In my view, if one follows the logic of the rules of the game of STDT, altruism (narrowly defined as sacrifice) is a pre-requisite of candidates of STDT because, from the therapist's point of view, it makes a therapeutic relationship possible. In other words, it is not an arbitrary fact that clients must have evidenced "altruism" in the past because, and in a very real sense, STDT requires that clients will have to establish a similar "meaningful and altruistic" relationship with the therapist. In addition, the manner in which the individual therapist interprets "altruism," that is, as sacrifice, etc. covertly obliges the client to manifest differing levels of motivation. In this way, the therapist exerts different levels of power/control over the client. In conclusion, what seemingly reads as a descriptive feature of STDT has actually been shown to take on a normative force in the context of treatment. The following case example of a college student suffering from psychoneurosis beautifully illustrates what a *sacrifice* might look like in STDT but also what might happen when a client "changes her mind" regarding this sacrifice:

> [Initial Evaluation:] She seemed to be motivated to understand the reasons for her symptoms and to realize

> that she had to work hard. When asked what *sacrifices* she was prepared to make, she answered that she was willing to cut some of her classes in order to keep her appointments in the clinic, despite the difficulties this might create for her.
>
> [Second Visit:} *Patient:* ... Now what about the change of the hour (of the appointment)? *Doctor:* I understand that you have a conflict of interest, but my schedule is somewhat rigid, and this is the only hour I have.
>
> One may view the therapist's attitude on this point as inflexible; but, *in his judgment*, he has to assess *the patient's manipulative tendencies and her somewhat contemptuous attempt* (emphasis mine) to make psychotherapy rank second to her studies. He, therefore, decides at this early point to draw the line.
>
> *Doctor:* What I said stands. If you want to see me it would have to be at this hour. *Patient:* You are going to become the reason for my flunking my exam. *Doctor:* Oh, come now, Miss N., I am surprised at you! After telling me that you are such a rational person and that you come from such a rational country, after emphasizing that you and your mother always think logically, after viewing me in a derogatory way, how could it be possible that *I* would be held responsible for *your* failing your exam?[33]

I believe that even D. Malan, who is not so adamant as the others that motivation is of paramount importance as a selection criteria (and especially as evidenced in the initial interview) may subtly be lending evidence to my thesis in the following passage:

> ...(the client) must show adequate motivation to attempt to solve his problems by achieving insight. This is an additional -- and equally important reason for giving interpretations during the assessment period; since in this way the patient has been provided with a foretaste of the kind of therapy he will be offered. *It is not necessary for his motivation to start high as long as it increases during his exposure to the clinical situation; correspondingly,*

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[33] Ibid., 198, 200-1.

> *decreasing motivation is a poor prognostic_sign*
> (emphasis added, mine).[34]

The interpretative connection that I am trying to establish here is that "signs" of altruism as evidenced in the therapeutic relationship/transference will eventually (as Malan notes above) emerge over the course of therapy and the expectation for what constitutes valid signs of altruism depends, in large part, on the level of patient motivation that is expected in therapy.

As a final point of historical interest concerning a meaningful relationship as a selection criteria of patients, it is important to note that it is here where, STDT sharply diverges from Freud's psychoanalysis. Like Freud, many dynamic theorists believe that childhood relationships are significant because the patterns in which they occur will invariably be repeated in the transference neurosis. Nonetheless, nothing is said about "altruism", let alone, of "give and take interactions" being a significant feature, according to Freud, in these early childhood relationships. As a result, they do not function as selection criteria for clients.[35]

The full ramifications of the above analysis of "altruism" will not fully be recognized until the third category, therapeutic techniques, has been explored. But at the least, a door has been opened to suggest that normative values, of a highly personal and covert nature, are operative in STDT.

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[34] Davanloo, *Basic Principles*, 59.

[35] Davanloo, *Basic Principles,* 9-10.

Client diagnosis

Assuming that the client satisfies the aforementioned criteria of selection, let us move on to the second rule of STDT, diagnosis. From the therapist's perspective, this category largely acts as the final determiner for recommending STDT to a client. As stated previously, clients exhibiting certain kinds of illness are not deemed to be good candidates for this kind of therapy, and as such, their treatment is not amenable to the therapeutic techniques of STDT. For this reason, I believe that this second category is logically tied to both the selection criteria of clients and hints at the kinds of therapeutic techniques that are used in STDT.[36]

The way in which STD therapists arrive at a diagnosis could complicate this analysis. Borrowing concepts freely from psychoanalysis, and interpersonal, neuroscientific and even to some extent, behavioristic schools of thought, STD theorists attempt to establish a unified diagnosis. Whether or not a unified or coherent diagnosis is possible in spite of the variety of the schools of thought upon which they base their thought is only peripheral to my thesis.

In this section, I will focus on a standard accusation leveled at proponents of STDT, namely: that the kinds of mental illness treated by STDT, as well as its cure,

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[36] For some acknowledgement of this fact in contemporary research on STDT see Leonard Horowitz, Saul E. Rosenberg and Kim Bartholomew, "Interpersonal Problems, Attachment Styles and Outcome in Brief Dynamic Psychotherapy," *The Journal of Consulting and Clinical Psychology,* vol. 61, no. 4, (1993): 549-560. "Some types of interpersonal problems seem to be more difficult to treat than others, and people who complain primarily of the more difficult types of problems would seem to be poor candidates for brief dynamic psychotherapy" 549.

are limited in nature and in scope.[37] What I would like to do now is to turn to a consideration of this matter: does STDT only offer superficial treatment for illnesses of a rather recent temporal onset, such as adjustment disorders?

A scientifically sound way of attacking this charge would be to demonstrate empirically that STDT can impact "characterological disorders."[38] There is at once an urgency on the part of STD therapists to claim that characterological change can *and does* occur in their form of brief therapy and at the same time a noted acknowledgement that STDT lacks outcome studies demonstrating such deep-level and long-term transformations.[39]

It is consistently noted that outcome studies must take into consideration the selection criteria of clients. That is to say, positive or negative outcome in *all forms of therapy* depend upon the kind of client that one treats, the nature of the presenting problem, etc. For this reason, just as Freud claimed that psychoanalysis requires that clients have a "reliable character," so too, and as noted earlier, STDT requires that

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[37] Davanloo, *Basic Principles*, 93.

[38] I have in mind here those illnesses that are identified in the *DSM-IV* as Axis II personality disorders.

[39] See David Malan "Exploring the Limits of Brief Psychotherapy" in Davanloo *Basic Principles,* Ch. 4; Lester Luborsky, Jacques P. Barber and Larry Beutler: "Introduction to Special Section: A Briefing on Curative Factors in Dynamic Psychotherapy," *Journal of Consulting and Clinical Psychology*, vol. 61, no. 4, (1993) 539-41; Coughlin Della Selva, *Intensive Short-Term Dynamic Psychotherapy,* particularly Ch. 7 on character change and p. 14 in which she notes the lack of outcome studies regarding character change; Manuel Trujillo and Leigh McCullough, "Research Issues in Short-Term Dynamic Psychotherapies: An Overview," in *Clinical and Research Issues in Short-Term Dynamic Psychotherapy"* ed. by Arnold Winston (Washington, D.C.: American Psychiatric Press, Inc.) 1985.

clients have a general "strength of character." Invariably, the diagnosis acts in much the same way. For this reason, it may be useful to consider a list of those *kinds* of clients that are, in principle, not deemed as good candidates for positive outcome in STDT. They are:[40]

- Suicidal Patients
- Substance Abusers
- Long-Term Hospitalized Patients
- Chronic Obsessive Compulsive Disorder (OCD)
- Chronic Phobias
- Patients treated by ECT
- Self-Destructive Persons

* Narcissistic & Borderline Personality Disorders
* Psychotics

It strikes me as curious that while STD therapists are seeking to make a broader claim that their form of therapy can impact "characterological disorders," in principle, they are excluding from treatment two kinds of "characterological disorders," notably narcissistic and borderline personality disorders. The curiosity increases, when one considers that from an historical point of view, Freud claimed that psychoanalysis was capable of treating the narcissist.[41]

One possible explanation for the exclusion of some of these illnesses is the

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[40] See David Malan, "Exploring the Limits of Brief Psychotherapy," Chapter 4, in Davanloo, *Basic Principles.*

[41] My inquiry in this section is limited to only those diagnoses that Freud thought psychoanalysis was capable of affecting. For this reason, I shall not address "self-destructive" clients; as stated, it is too vague of a description to be certain if Freud treated such clients. In addition and obviously due to advances in technology, the comparison can not be made for patients who underwent ECT treatments. The clearest example of a diagnosis which Freud claims to treat and STD therapist exclude is the narcissist. For that reason, my investigation will be limited to this diagnosis.

length, strength and number of symptoms that a client possesses. If these are considered too severe to be overcome in brief therapy, then, the patient is not deemed a suitable candidate. Indeed, one could make the case that it is exactly this kind of reasoning that is employed in STDT's decision to treat persons with OCD or phobia but not those with *chronic* OCD or *chronic* phobia.

However, I think the above is a shallow explanation precisely because it does not account for the exclusion of narcissists and borderline clients from treatment. Rather, I wish to suggest an alternative explanation that might function as the real rationale for why such persons having these characterological disorders are deemed unacceptable candidates for this kind of therapy. In brief, *by definition* of the disorders themselves, both narcissists and borderlines have severe problems forming relationships with others.[42] The therapeutic relationship that is necessary in STDT is of such a *kind* as to require the client -- immediately and unequivocally -- to *willingly accept* the therapist's interpretation of what the proper focus of treatment *should* be. Only when this is accomplished can the therapist employ the techniques of STDT and move on, if you will , to the next "rule of the game," namely the techniques of therapy. I believe that both the importance and clarity of this thesis emerges when one compares Freud's reasons for claiming that psychoanalysis can be a successful form of therapy for narcissists. It is Freud's underlying notion of the therapeutic relationship that accounts for his claim to do so. In the end, what will be

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[42] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed., rev., (Washington, D.C.: APA, 1994), 650, 654.

demonstrated is how radically different STD therapists understand the nature of this relationship and how, to a much greater degree than psychoanalysis, a therapist's personal values may be said to guide the course of therapy.

A place to begin this analysis lies with the kind of client that both Freud and STD therapists would agree could not be treated, namely the psychotic. On several occasions, Freud stated that it is impossible to treat the psychotic - the clearest instance of the person with "loose" connections with reality. In *An Outline of Psychoanalysis*, Freud says:

> If the patient's ego is to be a useful ally in our common work, it must however hard it may be pressed by the hostile powers, have retained a certain amount of coherence and some fragment of understanding for the demands of reality. But this is not to be expected of the ego of a psychotic; *it can not observe a pact of this kind, indeed it can scarcely enter into one. It will very soon have tossed us away and the help we offer it and sent us to join the portions of the external world which no longer mean anything to it.* Thus, we discover that we must renounce the idea of trying our plan of cure upon psychotics - renounce it perhaps for ever or perhaps only for the time being, till we have found some other plan better adapted for them.[43]

What is important about the above quote is that, in some sense, it is not the diagnosis per se of being a psychotic which does not allow for such individuals to be treated with psychoanalysis; but rather, from the therapists point of view, the diagnosis has a *meaningful implication* for the possibility of establishing a "viable" therapeutic relationship. Establishing the appropriate kind of relationship is a necessary

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[43] Freud, *SE* 23, 173.

requirement for the very possibility of "doing" psychoanalysis. A s Freud says, if a client can not be a "useful ally" and form a "pact" with the therapist, it is the therapist that must "renounce" psychoanalysis as a form of cure for the client.

By contrast, Freud did think that narcissists could fulfill the above requirements. Provided that the individual has not broken off all connections with the external world, as is the case with schizophrenics, Freud believed that psychoanalysis could be a viable form of treatment for many individuals suffering from narcissism. He explains this distinction as follows:

> A pressing motive for occupying ourselves with the conception of a primary and normal narcissism arose when the attempt was made to subsume what we know of dementia praecox (Kraeplin) or schizophrenia (Bleuler) under the hypothesis of the libido theory. Patients of this kind whom I have proposed to term paraphrenics, display two fundamental characteristics: megalomania and a diversion of their interest from the external world -- from people and things. In consequence of the latter change, they become inaccessible to the influence of psychoanalysis and cannot be cured by our efforts. But the paraphrenic's turning away from the external world needs to be more precisely characterized. A patient suffering from hysteria or obsessional neurosis has also, as far as his illness extends, given up his relation to reality. But analysis shows that he has by no means broken off his erotic relations to people and things. He still retains them in phantasy... ... But the megalomania itself is no new creation; on the contrary, it is, as we know, a magnification and plainer manifestation of a condition which had already existed previously. This leads us to look upon the narcissism which arises through the drawing in of object-cathexes as a secondary one, superimposed upon a primary narcissism which arises through the drawing in of object-cathexes as a secondary one, superimposed upon a primary narcissism that

is obscured by a number of different influences.[44]

Even with this severe symptomatology, the narcissist, for Freud, is an acceptable candidate for treatment in his psychoanalysis. Even though, his capacity to form interpersonal relationships is questionable, the narcissist is capable of forming a viable therapeutic relationship with the analyst. The narcissist is capable of the following:

> The analytic physician and the patient's weakened ego, basing themselves on the real external world, have to band themselves together into a party against the enemies, the instinctual demands of the id and the conscientious demands of the super-ego. We form a pact with each other. The sick ego promises us the most complete candor - promises, that is, to put at our disposal all the material which its self-perception yields it; we assure the patient of the strictest discretion and place at his service our experience at interpreting material that has been influenced by the unconscious.[45]

And how, one might wonder is candor evidenced within the therapeutic relationship, according to Freud? One sign would be the client's pledge to "to obey the *fundamental rule* of analysis."[46] This, of course is free association, a main technique of psychoanalysis.

I spent some time quoting Freud at length because it seems to me that his sense (at least in these passages) in explaining the nature of the therapeutic relationship emphasizes an important value that lies at the root of the therapeutic relationship. Candor allows for the possibility of the pact formation and enables the

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[44] Ibid., 14: 74-75.

[45] Ibid., 23: 173.

[46] Ibid., 23: 174.

technique of free association to occur in the therapeutic encounter. But more importantly, the therapist informs the client that candor is required; indeed, the patient "pledges" to commit to such sincerity. Freud reasons that the narcissist, even despite the extreme nature of the pathology, is quite capable of *willingly* agreeing to be candid, and thereby free associating in therapeutic sessions.

Unlike Freud, STD therapists offer vague descriptions of the therapeutic relationship that is necessary to successful outcome in their form of treatment. At times it is said that a "joint agreement" must exist between the client and the therapist. At other times, it is suggested that only "part" of the client can, in principle, jointly agree to therapeutic work while simultaneously another "part" of the client will actively resist any therapeutic endeavor.[47] What concerns me is their repeated failure to acknowledge that STD therapy requires that the client possess *other values*, in addition to candor if this form of therapy is to succeed. More boldly and as will soon be made clear, STD therapists encourage clients to adopt certain "values" as opposed to others in the confines of therapy. For now it is sufficient to note that if candor were the only value that is necessary for the therapeutic relationship and if STD therapy *can* accomplish characterological change, as these therapists claim it can, then the narcissist should in principle be an acceptable candidate for treatment. And as noted, he is not.

One reason why a discussion of client values/norms may be overlooked by

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[47] Patricia Coughlin Della Selva. *Intensive Short-Term Dynamic Psychotherapy* (New York: John Wiley & Sons, 1996), 14.

STD therapists is that the therapeutic relationship is typically discussed from the point of view of the therapist. The following quote illustrates this:

> According to Davanloo (1980, 1990), the therapist must abandon the passive stance and work actively to bring the patient's conflict into focus, intensifying the affective involvement and creating an intrapsychic conflict that makes rapid change possible.... In this way, the BFSTDP *therapist is not neutral but adopts a therapeutic stance that advocates openness and honesty,* (emphasis added) even when painful. The therapist communicates a serious but dedicated approach to getting at the truth (Malan has referred to this as "the iron hand in the velvet glove"). It is clear to the patient from the outset that the therapist is working diligently and is presenting a challenge to the patient to join in and work at his or her highest level of ability.[48]

In the above passage, the therapist admits that her stance is "non-neutral" insofar as she "advocates" openness and honesty on the part of the client. One could easily interpret "openness and honesty" as equivalent to Freud's notion of candor. Again, if this were the only value that were assumed in this form of therapy, then the narcissist by definition (and given STD therapists' purported goals of affecting characterological change) should, in principle, be capable of treatment. However, I would urge the reader at this point to focus on the last part of the above quote. In addition to encouraging "openness and honesty," the therapist is also said "to challenge the patient to work... at his or her highest level of ability." In the abstract, the therapist, in her non-neutral stance is encouraging the client's motivation. As described in the foregoing section, it was noted that motivation is broadly evidenced in terms of "altruistic" behavior. The asymmetrical nature of the therapeutic relationship seems to

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[48] Ibid., 14-15.

presuppose at least one (some) values in addition to candor.

By way of concluding this discussion, we have seen that formulating a diagnosis in STDT is both a final determination of the selection criteria of STDT and hints at the kinds of techniques that will be used in this form of therapy. *At the outset of therapy,* the client is assumed to possess some other values, in addition to candor, or openness and honesty. If the client does not possess these, the therapist, in her "non-neutral" stance, may encourage clients to adopt values in the course of therapy. Even though both Freud's psychoanalysis and STDT are "dynamically" based theories, Freud allowed for treatment of the narcissist because his conception of the nature of the therapeutic relationship emphasized only the value of candor. STDT presupposes other values in addition to candor on the part of the client. This final point makes it obvious as to why STDT is fundamentally different from Freud's psychoanalysis (long-term therapy). Free associative techniques imply a lengthier treatment of the individual and, at the very least, a more egalitarian notion of the nature of the therapeutic relationship.

In the next section, I will explore the sense of therapeutic techniques that are made use of in STDT and see how this next rule may affect the actual and normative goals of this form of therapy.

Techniques of therapy

Following in the footsteps of Freud, STD therapists use interpretive techniques in the course of therapy. Even today, clients are said to have unresolved Oedipal

Conflicts and symptomatology is said to result from unconscious sexual wishes.[49] In this section, I choose not to focus so much on the content of the interpretations; but rather, on the following issues: 1) the appropriate time to offer interpretations in the course of therapy, 2) the various *classes/categories* of interpretation that therapists may use and 3) the way in which therapists are trained to use these techniques.

Discussing the timing of interpretations may seem, to some, to be a relatively unimportant topic. However, it is one of the ways in which STD establishes itself as a novel version of dynamic therapy. Freud has much to say about the timing of interpretations and the impact that this may have for the outcome of therapy. For this reason, consideration of Freud's comments on this point may be a useful tool with which to further assess the impact that this could have upon the goals of therapy.

In numerous texts, Freud cautions therapists against making use of interpretation too soon in the therapeutic process. Based on his own clinical experience, Freud warns of the negative consequences of this form of therapeutic technique. For example, in *On Beginning the Treatment*, he says:

> It is true that in the earliest days of analytic technique we took an intellectualist view of the situation. We set a high value on the patient's knowledge of what he had forgotten, and in this *we made hardly any distinction between our knowledge of it and his.* We thought it a special piece of good luck if we were able to obtain information about the forgotten childhood trauma from other sources - for instance, from parents or nurses or the seducer himself - as in some cases it was possible to do; and we hastened to convey the information and the proofs of its correctness to the patient, in the certain expectation

[49] For discussions of specific cases see Davanloo, *Basic Principles*, 316.

> of thus *bringing the neurosis and the treatment to a rapid end.* It was a severe disappointment when the expected success was not forth-coming. How could it be that the patient, who now knew about his traumatic experience, nevertheless still behaved as if he knew no more about it than before? Indeed, telling and describing his repressed trauma to him *did not even result in any recollection of it coming into his mind* (emphasis added, mine).[50]

It is clear from the above comment that Freud's early observations of imparting interpretations too quickly led to some unpalatable consequences: 1) the inability to distinguish between the content of the knowledge achieved (at the conscious level) as being that which is proper to the therapist or the patient and 2) rushing a suggestion further repressed unconscious. Taken together, one could argue that at least in this passage Freud was concerned with a client's autonomy; presumably, it is important for clients to possess their own knowledge and this, of course, would presuppose that unconscious material has been dealt with at the conscious level. But let us consider some other negative effects. Freud notes that:

> It is not difficult for a skilled analyst to read the patient's secret wishes plainly between the lines of his complaints and the story of his illness; but what a measure of self-complacency and thoughtlessness must be possessed by anyone who can, on the shortest acquaintance, inform a stranger who is entirely ignorant of all the tenets of analysis that he is attached to his mother by incestuous ties, that he harbors wishes for the death of his wife whom he appears to love, that he conceals an intention of betraying his superior, and so on. I have heard that there are analysts who plume themselves upon these kinds of lightning diagnoses and 'express' treatments, but I must warn everyone against following such examples. Behavior of this sort will completely discredit oneself and the

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[50] Freud, *SE* 12: 141.

> treatment in the patient's eyes and will arouse the most violent opposition in him, whether one's guess has been true or not; indeed, the truer the guess the more violent will be the resistance. As a rule the therapeutic effect will be nil; but the deterring of the patient from analysis will be final.[51]

The above probably represents the most curious passage, especially in light of the techniques of STD therapists, for there are several different nuances within Freud's cautioning against rapid interpretations. There is a level in which Freud seems to be implying that such treatment between "strangers" simply violates the established rules of etiquette; but most importantly, it does in fact, increase the resistances present on the part of the patient. Again, irrespective of the content of the interpretation, Freud claims that there are at least four possible negative consequences that the timing of an interpretation may be said to have for the client. One wonders, how might STD therapists respond when faced with such consequences?

Interestingly, many of Freud's concerns are lessened by the selection criteria of clients. For example, Freud's noted worry about possibly alienating the patient from psychoanalysis -- and therapy in general -- is mitigated by the fact that STDT ensures that clients are highly motivated individuals who possess a "strength of character." Potential alienation of the client because of a stranger imposing a strange myth upon the patient, again, because of the selection criteria seems to be highly unlikely, and may in the end say more about Victorian etiquette rather than our own.[52] Similar in

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[51] Ibid., 12: 140.

[52] See Coughlin Della Selva, *Intensive,* Ch.1.

vein is the fact that Freud argues that early interpretation may misconstrue diagnosis. This is clearly not a concern of STD therapists who believe that diagnosis can and ought to occur within the initial interview.

What is curious, though, is Freud's concern that early interpretation can (and negatively for the goals of therapy) deepen a client's resistances. Many STD therapists (notably Peter Sifneos) seem to relish the fact that resistances are strong and that they can only be combated by anxiety-provoking measures. Perhaps, at this time, it is appropriate to make the transition to this seemingly novel and odd (on psychoanalytic terms) technique and ask the question: What is the justification for anxiety-provoking or even "highly confrontational, almost adversarial techniques?"[53]

In some sense, the justification for all or any of the techniques used in STDT rests, once again, with the selection criteria for clients. Consider the following claim by Sifneos:

> ... staying within the designated and agreed-upon focus increases anxiety and brings about resistance. When that happens, the therapist is faced with a dilemma. Should one persist in making the patient more and more anxious and thus resistant, or should one become more supportive and try to diminish the effect - in short, become anxiety-suppressive?
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> The STAPP therapist persists in making anxiety-provoking confrontations and clarifications. Here again the therapist counts on the patient's motivation for change. Despite unpleasant emotions, the patient will understand the need to come to grips with the

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[53] Ibid., xiii. Also: A general list of these techniques has been distilled from Davanloo's, *Basic Principles*. They include: interpretation, clarification, confrontation, suggestion, manipulation.

anxiety once and for all, for the sake of recovery.[54]

An case example of a therapist employing this technique is useful to consider. Sifneos cites the following and the reader will soon see why it is worth quoting at length:

> If a patient brings up information about some form of acting out which seems to be antitherapeutic, the therapist might say: "It appears to me that your action is completely contrary to what we have been talking about. Under these circumstances, therefore, I think that there is no need for us to go on, because it is clear that you are not interested in solving your problems if you act out against your own therapy."
>
> Such a statement usually will produce a great deal of anxiety because the patient's motivation for change has been challenged Patients usually vehemently deny that they want to discontinue their therapy, and they also agree that acting out will be counterproductive.
>
> If, on the other hand, the patient has used acting out as an excuse to terminate treatment because it is too anxiety provoking, it would be concluded that the original evaluation of the patient's motivation for change was faulty and that the patient was not an appropriate candidate for STAPP.[55]

By now, the analogy made between a game and its rules and the logic of STDT should be apparent. According to Wittgenstein, the rules of a game define the parameters of success/failure within the game. But what I would truly like the reader to notice in the above passage is that if one compares STDT to a game, the players in this game do not occupy "equal" positions. Quite simply, the client does not have the same opportunity nor power, as does the therapist, to make use of the "rules." Because of this, *within the boundaries of STDT*, the client is really a powerless player

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[54] Sifneos, *Short-Term,* 108.

[55] Ibid., 109.

in his own treatment. The above passage offers an excellent example of this theme. If a client persists in certain behavior (in this case, what is considered *by the therapist* to be a form of "acting out,") then, *within the game of STDT,* the client has only one choice: namely, to change the behavior. Persons who have only one choice in a certain situation, in a very real sense, have no choices at all. I suspect that STD therapists could say: Ah, but the client could leave and find another therapist. Admittedly, this is true. But note, if a client were to make this "decision," he *is forced to step outside of the game of STDT* in order to experience any "real choice" whatsoever. The utter significance that this point has is when one realizes how a STD therapist, such as Sifneos, might explain a client's decision to leave therapy. For if this were to occur, the therapist bears no responsibility for *this* decision. Rather, the therapist need only chide himself for having made an initial error in selecting the client for treatment because the client is said to have lacked (all along!) the necessary "level of motivation" for treatment. The therapist need only take responsibility for an initial error in his judgment -- but *nothing* else.[56]

Before leaving the above cited passage, one other issue deserves to be mentioned. An implication of the passage is that client's who "acquiesce" to the anxiety-provoking comment and/or do not see it as a viable option to terminate therapy, are said *(and from the therapist's point of view)* to have bolstered their sense

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[56] Undoubtedly, when the success rate of this form of therapy is considered in the next section, the reader would do well to remember this point. As we will see, to a large degree the success/failure rate of this form of therapy rests with the *therapist's* clinical observations of the client.

of "motivation" to continue to explore the central issue of therapy. The obvious question that this leaves us with is: When using anxiety-provoking techniques, is it really the case that therapists have augmented the motivation of their clients? Or rather, have STD therapists really fostered a sense of passivity (a decrease of autonomy) within their clients to accept the interpretation offered? A plausible argument could be made which claims that, as part of their selection criteria, STD therapists ultimately choose to treat clients who *lack confidence in themselves or their ability to make autonomous choices.*[57] Unfortunately, a complete examination of this claim would take me too far afield at this point; yet, one must remember that within the game of STDT, it is the therapists who have the sole power to interpret and use the rules of the game.

By way of concluding this section, I wish to briefly consider how technique is said to depend upon a therapist's "individual style." Perhaps unlike any other paradigm explored in this dissertation, STDT touts the fact that techniques of therapy should be chosen based upon the individual personality of the therapist. As cited earlier, Sifneos has stated that a therapist's "individual style" can neither be "taught or described." Even beyond this, STD therapists seem to be comfortable in claiming that a choice of techniques may have to do with a therapist's unconscious motivations. In

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[57] Again, the reader should remember this claim in light of the forthcoming paragraphs. STD therapists suggest that the ultimate choice of a therapist's techniques are often based on unconscious "reasons" or "motivations." If this is so, one can not help but wonder if therapists are unconsciously selecting clients who are passive or weak-willed.

the end, though, individual style is not something to avoid in STDT; if anything, it is strongly encouraged. However, after reading about the preferred techniques of the leading thinkers in this field, one wonders to what extent the individual styles which have "worked so well" can ever be replicated by anyone else who hopes to *learn* this form of therapy. I believe that two very important issues depend upon whether or not techniques can in principle be "imitated" or "taught:" 1) If techniques can be taught, one can speak consistently and honestly about STDT as constituting a discipline. There is certainly a dearth of evidence which suggests that STD therapists see themselves as theoretically articulating and practicing from within an established discipline/school of thought. 2) However, if the techniques of this form of therapy can not, in principle, be taught to those new to the field, then the disciplinary status of STDT is rendered questionable. In light of this last claim, consider the following passages:

> My own perception of Davanloo as a therapist has always been that of a leopard, or other wild animal in his natural environment, guided by *infallible instinc*t who, at any given moment, knows exactly what direction to take and which strategical moves are best suited to accomplish *his* aim... (emphasis added, mine) [58]

> ... there is not much point in imitating Davanloo's visible moves, hoping to be as effective without understanding and assimilating the underlying theory, so as to adapt it to one's own personality. Clearly, not all of us are leopards, and trying to imitate one, even by using a therapeutic manual, would be not only ridiculous but a

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[58] Feruccio Osimo, "Method, Personality and Training in Short-Term Psychotherapy," *International Journal of Short-Term Psychotherapy*, vol. 9, (1994), 180.

> gross oversimplification. Conversely, each of us has got his own unconscious and, even while we are trying to follow a certain model, we should never overlook its signals.
>
> This having been said, it remains evident that Davanloo's technical interventions are often totally original, and differentiate his approach from all the others.[59]

> In 1995, I wrote that perhaps Davanloo's most important contribution has simply been the demonstration that widely applicable brief psychotherapy is *possible*, so that other therapists are encouraged to use some of his ideas to find equally effective methods that suit their own personalities. Dr. Coughlin Della Selva has unquestionably done this, and the next step will be much easier; namely, for yet other therapists to adapt her technique to suit *their* personalities -- in which process, the publication of this book will play an essential part. I hope the result will be a chain reaction by which the whole status of psychotherapy may ultimately be transformed (emphasis added, mine).[60]

I imagine that Malan envisions a positive transformation for psychotherapy. I am wary of such optimism. With techniques taught in this manner to individuals who want to learn STDT, I can only envision a "chain reaction" that leads to a further enslavement for potential clients of this increasingly subjective "discipline."

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[59] Ibid. See also: D. Malan, foreward in *Intensive,* by Coughlin Della Selva, xiii-xiv: "The reasons seem to include above all, the extreme difficulty of learning Davanloo's technique, with the result that only a handful of therapists other than Davanloo himself can use it effectively. This partly stems from his use and advocacy of a highly confrontational, almost adversarial, style. Although such an approach is extremely effective in his hands, many other therapists do not feel comfortable with it. Moreover, there has never been any textbook to facilitate the learning process."

[60] Ibid., xv.

Goals of STDT

If it is indeed the case that individual style is a laudable means for therapists to choose their techniques, then one has to wonder how the goals of treatment are to be assessed in this form of therapy. Specifically, one wonders if there can be generalizable results of this form of treatment. Davanloo claims that the "individual personality characteristics and the empathy of the therapist" are "crucial for the outcome of therapy."[61] The literature suggests that STDT aims at the following plethora of *possible* "outcomes" for the client:

> - insight; characterological change; psychodynamic change; insight into emotional conflicts and understanding symptoms in dynamic terms; main (circumscribed focal) conflict has been accomplished; patient feels better; new attitudes have been developed; increase in self-esteem.[62]

Let us begin by focusing on what is *not* listed as a possible goal:, namely a change in clients behavior and/or symptomatology. This will lead to a further consideration of the *criteria* that is used to assess client goals of STDT.

Since its inception in the late 1960's and early 1970's, there has been a surge of interest in generating (presumably, replicable) outcome studies of what is actually achieved within STDT.[63] Curiously, Sifneos notes that while his version of STDT has had great success in provoking increased patient insight, actual "change in

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[61] Davanloo, *Basic Principles,* 31.

[62] Ibid.

[63] See Winston, *Clinical and Research,* Ch. 7.

symptomatology has not been impressive."[64] Whether or not therapists can empirically demonstrate a necessary causal link between "interpretation" and change in behavior/symptomatology is beyond the scope of this present analysis. However, what is of concern is whether or not STD therapists assume responsibility for informing their clients that "increased insight" *may or may not result* in changes in their symptomatology. It seems to me that many clients seek therapy precisely because they are suffering from certain symptoms and/or behavioral difficulties. If statistical studies do not adequately -- even to STD therapists requirements for adequacy -- demonstrate that changes in symptomatology do occur, it would seem that a therapist *must assume the obligation* to inform clients of this fact. As I have shown, STD therapists are eager to talk about establishing a "joint agreement" with the client regarding the "central focus" of the therapy, to encourage a client's motivation in the course of therapy, to require that the client make "sacrifices" for therapy, etc. Unfortunately, there is a noted absence in the literature regarding a STD therapist's *obligations* to inform the client both of the possibilities and *the very real limitations* of this form of treatment.[65]

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[64] Ibid., 40.

[65] Unfortunately, space does not permit a complete development of the ethical importance of this observation. My thesis is limited to a demonstration of *where* normative assumptions might occur in STDT in virtue of examining its theoretical commitments. The reader, however, should bear in mind that by saying therapists have an obligation to tell clients of the limitations of this form of treatment, the justification for this obligation arises from a therapist's knowledge of *this particular paradigm*. It may be the case that therapists with other theoretical orientations may not have this obligation (i.e. clients who seek treatment from behavioral therapists may experience better/more noticeable changes in their symptomatology. As such,

Some therapists might object and argue that *most* clients who seeks STD therapy will somehow "improve" at the end of treatment. That is to say, *most* clients will benefit even though the actual benefits may not be capable of empirically confirmation. This *may* be true; but, I would argue that one will never know the extent to which *a client benefits* from this form of therapy so long as *a therapist's perspective* is privileged in generating the data for the outcome studies. All too often, STD therapists privilege their perspective. Consider the following claims:

> Davanloo claims to have done systematic follow-up of his patients, no systematic follow-up has really been published, so that the true quality of the majority of his therapeutic results is not accessible to us.
>
> Hopefully, the potency of this model will be confirmed also by outcome studies of the therapies *carried out by therapists* (other than Davanloo) applying his method. The lack of published clinical studies, reporting the relevant material and a discussion of exactly what changed and what did not change, is a shortcoming that should be filled.[66]

> Another important difference from psychoanalysis is that technique, selection criteria, content of interpretations types of interpretation, are more often based on direct cumulative evidence from previous empirical observations and outcome research data, rather than on purely metapsychological assumptions. In a way, Malan's metapsychological position is that he neither accepts passively nor thoroughly rejects some of the metapsychological foundations of psychoanalysis, but rather, he bases his clinical

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behavioral therapists may not be obliged *in the same way* as are STD therapists). This is one important implication. But there is a second and more important consequence that follows. Both therapists and philosophers who purport to write about "psychiatric ethics" should recognize that the therapist's obligation in this context is *not* derived from an abstract code of ethics. That is to say, there are obligations and responsibilities in psychiatry that receive their specific content from the school of thought from which they are derived.

[66] Osimo, *Method, Personality,* 182-3.

> judgement only on those metapsychological aspects which can be empirically validated by virtue of *clinical observations.* [67]

The issues concerning the criteria for assessment are, indeed, highly suspect. On the one hand, Davanloo, a founder of STDT, is portrayed as having no discernable outcome studies. On the other hand, Malan, who has outcome studies available, bases his clinical judgments on his own clinical observations. There is something oddly circular about this criteria. The circularity that I see might be made clearer by an analogy. One might imagine a college professor who evaluates students' performance based solely upon *his* own observations of individual students. Such a professor might administer tests, quizzes or even assign papers; however, the method by which he chooses to grade the assignments is his *personal* reaction to the work. If professors determined students' grades in this way, I believe that students would scoff at the unfairness of this approach. In this example, there exists no objective measures that *both* the student and professor could appeal to in order to evaluate the student's performance (i.e. mastering the material in a textbook, following the assignment for the paper, etc.).

I believe the above analogy pinpoints what is wrong with the criteria of assessing STDT. Clinical judgments of a therapist based on clinical observations that issue from the therapist create a radical subjectivity in the domain of STDT. Outcome of a client's success is again, a matter of therapist interpretation.

In his book, *Short-Term Anxiety Provoking Therapy*, Sifneos offers the

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[67] Ibid., 183-184.

following account of judging "successful/non-successful" outcomes. In some sense, it could be considered a way of circumventing the radical subjectivity involved in Malan's technique. He says:

> During the past fifteen years, I have had the opportunity to present in workshops, conferences, and seminars all over North and South America and Europe, my work about a kind of short-term dynamic psychotherapy called STAPP (short-term anxiety-provoking psychotherapy).
>
> I am pleased to find that a great deal of interest has been aroused among the participants. There are two reasons for this. The first has to do with the many years of investigation surrounding this kind of psychotherapy of brief duration, as well as the systematic studies of the results obtained. Second, we have made extensive and systematic use of video-tapes to demonstrate this work, allowing evaluation and techniques to be observed and outcome findings to be assessed objectively by the participants. It is they who watched critically the nature of the patient-therapist relationship and it is they who could decide whether the patients had improved.[68]

Video-taping has transformed the hitherto private therapeutic relationship into a publicly observable event. But, while the use of video-tapes is a step in the right direction toward infusing STDT with a modicum of objectivity, the fact of the matter is that the criteria of success or failure of STAPP is still highly infused with subjectivity. Community consensus *of therapists* determines the overall sense of the client's improvement. An equally disturbing notion is that "improvement" here defined is limited to the number of video-taped therapy sessions -- leaving it a completely unexplored issue as to whether or not "improvement" transcended the confines of therapy.

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[68] Sifneos, *Short-Term,* ix.

Given the above, I maintain that evaluating the outcome of STDT by using the criterion of a therapist's own clinical observations or a community of therapists' observations (as in the case with video-taping) is highly suspect. The reader should note that I do not believe that *any* paradigm of psychotherapy admits of the kind of measures of objectivity that one might expect in other sciences. However, in order to ensure the disciplinary viability of STDT as a paradigm of psychotherapy, I do believe that something *less subjective* or something that takes into account more than simply the therapist's perspective is desperately needed.

In her recent book, *Intensive Short-Term Dynamic Psychotherapy,* Patricia Coughlin Della Selva would appear to agree with that claim. Discussing the importance of outcome data, she says: "Such data are essential to determine whether our interventions are truly curative."[69] At the close of her book, she summarizes two methods for evaluation which do take into account the *client's* perspective. These methods were proposed by Malan and Davanloo respectively:

> The Tavistock group developed a rating scale to categorize patient response to treatment both at termination and follow-up. (Malan, 1963) The criteria for success were as follows: 0 indicated no change; a score of 1 represented some symptomatic improvement but no evidence of greater coping skills in the area of the core conflict; a score of 2 reflected meaningful symptomatic improvement plus evidence of new coping strategies for dealing adaptively in previously conflictual situations; and a score of 3 indicated broad change beyond the specific conflictual area to reflect greater coping in relationships with both men and women and better performance at work.

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[69] Coughlin Della Selva, *Intensive,* 226.

> Davanloo (1978) reported that of 130 patients deemed suitable for ISTDP, 115 were successfully treated in an average of 20 sessions. These positive results were maintained in follow-up interviews conducted between 2 and 7 years posttreatment. Davanloo engaged patients in active reassessment of the process at follow-up. Both patient and therapist watched videotaped segments of treatment. Davanloo engaged patients in an active reassessment of the process at follow-up. Both patient and therapist watched videotaped segments of treatment. Davanloo asked for feedback from patients and elicited their comments about what they had found helpful. Of significance was a frequently reported perception that the patients had done most of the work themselves. They tended to report feeling "free" or "like a new person," attesting to the dramatic changes that had occurred as a result of their hard work.[70]

While both of these kinds of evaluation represent a move toward greater objectivity in STDT by taking into consideration the client's perspective, the reader should still be wary of both kinds of these methods.. A careful consideration indicates that the client's perspective is solicited *only* with respect to what he/she found "helpful" about therapy. In short, both the questionnaire and the follow-up interviews ask clients to address what worked about therapy. Only in the first example is the client asked to report about aspects of his/her life in which there is "no change." However, one must wonder: should not the client's perspective be required about aspects of his/her life which might have been "negatively" affected? Posing the questions in this way makes it seem as if therapy can either "affect no change in the client's life" or "affect change for the better." I believe that there is a third category that is woefully missing from the methods of evaluation, namely: "negative affect." With "negative affect" not

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[70] Ibid., 226-227.

even being an option, it is no wonder why STDT reports such a high percentage of successful outcomes.

Conclusion

At the beginning of this chapter, I compared the paradigm of STDT to functioning like a game. I did so in order to see where and how the normative force of this paradigm's assumptions might enter into treatment. Having analyzed the many rules of this game: the meaning of the many selection criteria of clients, the kinds of illnesses treated, the treatment techniques and the goals/outcomes of therapy, it seems rather obvious that all of these categories encourage the therapist's personal values to enter into treatment. Any attempt to generalize what these values are would be risky; for, as we have seen, they literally depend upon each individual therapist's interpretation of the rules. An implication of this is that any attempt to generate a coherent, rational plan of action that benefits the client is sadly out of reach. The theory of this paradigm itself demonstrates that the utterly powerless players in their own treatment -- the clients -- must literally make a leap of faith in their therapist and hope that he/she is a good soul.

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DISSERTATION APPROVAL SHEET

The dissertation submitted by Sally R. Kowalkowski has been read and approved by the following committee:

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

December 1, 1997
Date

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